DEPT.- 65

JOB- 21

REEL- 41

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED D'RING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber M.D. Title: Commissioner of Health 3/15/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B	C
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐ To be sold as scrap or waste paper	☒ To be Burned or shredded	☐ Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force Records Management Officer 3/18/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

KF 29907

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54302

CERTIFICATE OF DEATH.

157 D 54302

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1840 n Duncan ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Moulden

(Residence in Baltimore. No. 1843 n Duncan St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 4, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 4 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Moulden

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Plock

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Moulden

(Address) 1843 N. Duncan St.

15-

Filed JUN 6 - 1921 191.. ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, June 6, 1921

20-UNDERTAKER Henry Lutz

ADDRESS 1007 N. Bond

CAUSE OF DEATH in plain terms, so that it may be easily understood. Abbreviations are important. See instructions on back of certificate.

Spec. 6-9-13—H. P. Co.—1000 Bks.

D 54303

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

55 D 54303

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.:) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Falck.

(a) RESIDENCE. No. 515 N Belnord Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER August Falck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUN 6 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921. to June 4 1921.

that I last saw h.e alive on June 4 1921.

and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY — (Secondary)

— (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Home

(Signed) W D Davison, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 7 1921

20 UNDERTAKER Henry Lutz — ADDRESS 1007 N. Bond

CAUSE OF DEATH. See instructions on back of certificate. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54304

54304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3501 Bank at ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Tantau

(a) RESIDENCE. No. 3501 Bank at ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs 4 mos 10 ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 26 1898

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk for 109

(b) General nature of industry, business, or establishment in which employed (or employer) Canton Bay Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER John L Tantau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie, Eckstorm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant Lena E Wellings
(Address) 917 E 1st Harrison Point md

15 FILED JUN 6-1921 ROBERT I KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1920, to June 5, 1921, that I last saw h m alive on June 4, 1921, and that death occurred, on the date stated above, at 10 15 a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. 7 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jacob Fisher, M. D

6/6 1921 (Address) 1823 N. Wash st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	6/7/21 19
20 UNDERTAKER	ADDRESS
Jno. G Denny	715 Light St

CAUSE OF DEATH must be plainly written. PENALTY FOR NEGLECT OF THIS DIRECTION is very important. See instructions on back of certificate.

D 54305

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54305

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 4 WARD)

2-FULL NAME Charles S Parran

(Residence in Baltimore: No. 202 N Pearl St. St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. April (Month) 4 (Day), 1861 (Year)

7-AGE. 60 yrs. 2 mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. James R. Parran

11-BIRTHPLACE OF FATHER. (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Alice Lockington

13-BIRTHPLACE OF MOTHER. (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas L. Parran

(Address) 323 E. 20th St.

15- Filed JUN 6-1921 191.. Registrar. ROBERT J. BRUTER

CAUSE OF DEATH. See instructions on back of certificate. important.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) ... yrs. a few hours mos. ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis & Alcoholism

(Duration) ... yrs. don't know mos. ds.

(Signed) H. K. Formad (Coroner) M. D.

6-6-, 1921 (Address) 17 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. Loudon Park

DATE OF BURIAL. June 7, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave.

6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54306

CERTIFICATE OF DEATH.

79 REGISTERED NO.

D 54306

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO. 1222 N. Mount ST. 19 WARD.
(Usual place of abode)

2-FULL NAME Lucy Taylor

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life 55 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE: Years 55 | Months | Days | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Hund (Address) 1226 N. Mound St.

15 Filed JUN 6 - 1921 ROBERT I. KRAUTER Registrar Burial Permit Dist.

CAUSE OF DEATH. See instructions on the other side. This INFORMATION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3rd 1921. to June 4th 1921, that I last saw h-r alive on June 4th 1921, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs mos ds

CONTRIBUTORY (Secondary) Chronic Myocardial Insufficiency (duration) 2 yrs mos

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Geo. H. Lautenbach M. D.

June 5, 1921 (Address) 2215 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: June 7 1921

20 UNDERTAKER: George H. Holland ADDRESS: 1631 Druid Hill Ave

D 54307

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54307

CERTIFICATE OF DEATH.

120

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1020 Sterling ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick C. Cermak

(Residence in Baltimore: No. 1020 Sterling St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, February 26, 1897
(Month) (Day) (Year)

7-AGE. 24 yrs. 3 mos. 7 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Joseph R. Schlow

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Catherine Fisch

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph R. Schlow

(Address) 1017 N. Carlin St

15- JUN 6 - 1921 Filed....., 191... ROBERT A KRAUSE Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. da.

(Signed) H. Kirby Hunter M. D.
(Coroner.)

6-5-, 1921 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, June 8, 1921.

20-UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager

CAUSE OF DEATH in plain terms. Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54308 ✓

D 54308

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) No. 731 W. Barre ST. 21 WARD)

2-FULL NAME. Albert Simmons

(a) RESIDENCE. NO. 731 W. Barre ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler work

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cincinnati Ohio

PARENTS

10 NAME OF FATHER Rich. Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary Cullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Simmons
(Address) 731 W Barre

15 Filed JUN 6 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1921, to June 4, 1921, that I last saw him alive on May 30, 1921, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease of heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. F. Lombardi, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: 6/7/ 1921

20 UNDERTAKER: E & B Storck — ADDRESS: 1151 E Lexington

CAUSE OF DEATH. See instructions on back. IMPORTANT. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 119 D 54309

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 Lafayette Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Bates

(a) RESIDENCE. NO. 505 Lafayette Ave ST.; WARD. Howard Co Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work "Gardiner" 82

(b) General nature of industry, business, or establishment in which employed (or employer) Gardener

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co Md

(State or country) Bal in Baltimore City & monther

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Carolyn Lawson (Bates)

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country) Maryland

14 Informant Clarence E Thompson

(Address) 505 Lafayette Ave

15 Filed JUN 6 - 1921 ROBERT J. KRAUS Registrar

Burial permit issued

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/2 1921, to 6/4 1921,

that I last saw h... alive on 6/4 1921,

and that death occurred, on the date stated above, at 6.25 P m.

The CAUSE OF DEATH* was as follows:

Ac. Nephritis &

Senility

duration 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Benj R Lewis, M. D.

, 19 (Address) 2 E Dr St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Riverstown Cemetery	June 7 1921
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott 2nd	Ashland Va

Spec. 6-9-13—H. P. Co.—1000 Bks.

D 54310

D 54310 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Kemp

(a) RESIDENCE. NO. 506 E. 42 St ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 11 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lavina Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) [illegible] Walbrook Md

15 Filed ..... 19 ..... Registrar Robert P. Harrison,

16-1921 Burial Permit Clerk.

TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1921, to June 5, 1921, that I last saw h[illegible] alive on June 5, 1921, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach
Gangrenous Gall Bladder
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Toxaemia Myocarditis
(duration) ..... yrs. mos. 18 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frances L. Kraney, M. D

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	June 6 19
20 UNDERTAKER	ADDRESS
W. P. Fulwood Son	Balto Md

Spec.—8-24-14—M. & T.—2000 Bks.

D 54311

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54311

CERTIFICATE OF DEATH.

40

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 Cecil ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida M. McCoy

(Residence in Baltimore: No. 1927 Cecil ave St.; 2 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, August (Month) 22nd (Day) 1861 (Year)

7-AGE, 59 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country). Marrion Maine

PARENTS.

10-NAME OF FATHER. Wm T. Reynolds

11-BIRTHPLACE OF FATHER (State or Country). Dennysville Maine

12-MAIDEN NAME OF MOTHER Hulda N. Greenough

13-BIRTHPLACE OF MOTHER (State or Country). Cooper Maine

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L.M. Bisson

(Address) 1927 Cecil ave

15-

Filed.....Robert P. Harrison, Registrar.

important. See instructions on back.

JUN 6 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 25 1921, to June 5 1921, that I saw h.r alive on June 1 1921, and that death occurred, on the date stated above, at 6 30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry Hayden M. D.

June 5., 1921 (Address) 1 East Lexington

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Haverhill Mass. DATE OF BURIAL, June 7th 1921

20-UNDERTAKER George Schilling & Sons ADDRESS 1126 E Monument St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54312

D 54312

CERTIFICATE OF DEATH.

55-001 Overlea

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Walnut Ave. 2nd House west of Cedar St. ST.; Overlea WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B. Stevens

(a) RESIDENCE. No. Walnut Ave. 2nd House west of Cedar St. ST.; Overlea WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara A. Stevens

6 DATE OF BIRTH (month, day, and year) Dec. 2nd 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Establishment

(c) Name of employer Rosenthals

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Henry Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Susan A. Rhuder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant Clara A. Stevens (Address) Overlea Md.

15 Filed JUN 6-1921 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1921, to June 4, 1921, that I last saw h[illegible] alive on June 23, 1921, and that death occurred, on the date stated above, at 10½ A. m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) Acute Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geary A. Long, M. D.

June 4, 1921 (Address) 27 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 7 1921

20 UNDERTAKER Fredk Lassahn & Sons ADDRESS Fullerton

TION is very important. See instruction

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54313 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54313

CERTIFICATE OF DEATH. 91-081

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital, Bay View 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Ahrens

(a) RESIDENCE. NO. None ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, New City Hospital.

15 Filed 6-1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1921, to June 5, 1921, that I last saw h er alive on June 5, 1921, and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis
No cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) W. H. Harman M. D.

6/6/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	6-6 1921

20 UNDERTAKER	ADDRESS
William Cook	502 E North Ave

TION is very important. See instructions on

20.54314 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.54314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE (No. Body found in the woods off Cherry Hill Road near River Road St., 21 WARD) — REGISTERED NO. C 183

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Savoy.(C)

(Residence in Baltimore: No. 745 Dover St.)

14 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single.

6-DATE OF BIRTH, August 10th. 1892., 1 (Month) (Day) (Year)

7-AGE, 28 yrs. 9 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), A. A. Co. Md.

PARENTS.

10-NAME OF FATHER, Louis Savoy.(C)

11-BIRTHPLACE OF FATHER (State or Country). A. A. Co, Md.

12-MAIDEN NAME OF MOTHER Maggie Deal.(C)

13-BIRTHPLACE OF MOTHER (State or Country). A. A. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Savoy.(C) father.

(Address) 832 W. Ostend St.

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

1921 Burial Permit Clerk.

CAUSE OF DEATH. Information is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Missing May 29, 1921 Body found June 3rd. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) .....find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Incised wound of the neck.....

.....Homicide.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto Kendall M. D. (Coroner.)

June 8., 1921. (Address) 10 E. Chases

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Dulaney Lane

DATE OF BURIAL, June 7th, 1921

20-UNDERTAKER David Forster

ADDRESS 916 Park Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54315

D 54315

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. Aged Women's Home ST.: 19 WARD)

2-FULL NAME Clarence White Home

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1400 W Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5-4 yrs. mos. ds. How long in U. S., if of foreign birth? 5-4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Blk	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaica

PARENTS

10 NAME OF FATHER Aged White Home

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica

12 MAIDEN NAME OF MOTHER Margaret Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica

14 Informant Ella J. Jones
(Address) Matron

15 Filed Robert F. Harrison, 19
Registrar
JUN 6 1921 Burial Permit Clerk.

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1921

17 I HEREBY CERTIFY, That I attended deceased from May 30, 19 21, to June 5, 19 21,
that I last saw h alive on June 5, 19 21,
and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Cerebral Sclerosis)

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What lest confirmed diagnosis?

(Signed) H H Norwood, M. D.

, 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	June 7 19 21

20 UNDERTAKER George J Smith

ADDRESS 1000 W Fayette

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 54316

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54316

CERTIFICATE OF DEATH.

REGISTERED NO. 8

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 714 Baker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Frank Bueck

(a) RESIDENCE. NO. 714 Baker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wht	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Theo. Bueck

11 BIRTHPLACE OF FATHER (city or town) Balto Co Md.
(State or country)

12 MAIDEN NAME OF MOTHER Dora Loher

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Mrs Theo Bueck
(Address) 714 Baker St

15 Filed JUN 5 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 5 1921, that I last saw h[illegible] alive on June 5 1921, and that death occurred, on the date stated above, at 9.00 P. m.

The CAUSE OF DEATH* was as follows:

Whooping-cough

CONTRIBUTORY (Secondary) Congestion of brain & Convulsions (duration) 12 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No.

What test confirmed diagnosis? Visible

(Signed) Edgehill, M. D.

6/6, 1921 (Address) 1600 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	June 7 1921

20 UNDERTAKER ADDRESS

Ehenowetholson Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54317 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54317

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp; #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. St.: 39 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Stephens

(a) RESIDENCE. No. US. Public Health Hosp.#56 St. 39 Ward. Baltimore Md.

(Usual place of abode) dont know

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs ... mos ... ds. How long in U. S., if of foreign birth? ... yrs ... mos ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Gertrude Stephens

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
28 yrs.		--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer): ---

(c) Name of employer: --

9 BIRTHPLACE (city or town) (State or country): Fla.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Edgar T Rosenbrock Registrar.

(Address) US. Public Health Hosp. #56

15 Filed ... 19... Robert P. Harrison, Registrar

JUN 6 1921 Burial Permit Clerk.

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June4 1921

17 I HEREBY CERTIFY, That I attended deceased from May 14 1921, 19... to June 4 1921, 19... that I last saw h im alive on June 4 1921, 19... and that death occurred, on the date stated above, at 7'30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary adv. active

(duration) 2 yrs. -- mos. -- ds.

CONTRIBUTORY (Secondary) ----

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of **

Was there an autopsy? No

What test confirmed diagnosis? Exam Clinic report

(Signed) J. D. Rickard, M. D.

, 19 (Address) US P.A Surgeon Temp. In Charge PHS Hosp. #56 FtMcHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	June 7 19
20 UNDERTAKER: David Taylor	ADDRESS 416 Conway

Spec.—8-24-14—M. & T.—2000 Blks.

D 54318 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54318

CERTIFICATE OF DEATH. REGISTERED NO. C 1042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 Myrtle Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Jones

(Residence in Baltimore: No. 402 Myrtle Ave St.: 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
M	Negro	Single

6-DATE OF BIRTH, June 3, 1920 (Month) (Day) (Year)

7-AGE, 1 yrs. mos. ds. If LESS than 1 day, hrs. or mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Gaston Jones

11-BIRTHPLACE OF FATHER (State or Country). N.C.

12-MAIDEN NAME OF MOTHER Lena Bagley

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Jones

(Address) 402 Myrtle Ave

15-

Filed Nov 5, 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 21 1921, to June 5 1921, that I saw h im alive on June 5 1921, and that death occurred, on the date stated above, at 6 0 m.

The CAUSE OF DEATH* was as follows:

Summer Complaint

(Diarrhoea)

(Duration), yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Rickets

(Duration) yrs. 7 mos. ds.

(Signed) J. Lucas Brown M. D.

6/6, 1921. (Address) 739 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem DATE OF BURIAL, June 7, 1921

20-UNDERTAKER Wood Taylor ADDRESS Cem

Important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54319

D 54319 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 West Belvedere Ave. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rosa Eisel

(a) RESIDENCE. No. "2 West Belvedere Ave. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Eisel

6 DATE OF BIRTH (month, day, and year) May 30"1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Sabastian Leckner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Heisler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Harry Eisel
(Address) 933 Hillen St.

15 16-1921 Robert P. Harrison, Registrar
. 19
Burial Permit Clerk.

TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 4th 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 2 . 1920. to June 4 . 1921.

that I last saw h alive on June 4 . 1921.

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno Magliss M. D.

. 19 (Address) 2008 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: June 7 1921

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 N. Bals St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54320 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 54320

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE; No. Charles cor. Mt. Vernon Place ST.: 11 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Conrad Lehr

(a) RESIDENCE. NO. Charles & Mt Vernon Place ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Dr Louis C Lehr

6 DATE OF BIRTH (month, day, and year) April 4 1887.

7 AGE: Years 37 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Lawrence L Conrad

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co Md

12 MAIDEN NAME OF MOTHER: Sallie R Worthington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co Md

14 Informant: Gordon Wilson (Address) 42 Preston St

15 Filed JUN 6 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 26th, 1921, to June 6th, 1921, that I last saw h. alive on June 6, 1921, and that death occurred, on the date stated above, at 4.25 a m.

The CAUSE OF DEATH* was as follows:

Migratory Broncho-Pneumonia

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? South of Washington

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray - Blood exams.

(Signed) Gordon Wilson, M. D.

, 19 (Address) 42 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holmsburg Worthington Valley Balto Co Md

DATE OF BURIAL: June 9 1921

20 UNDERTAKER: Henry J Jenkins Sons Co

ADDRESS: Orchard & McCulloh Sts

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54321

CERTIFICATE OF DEATH.

8-09/10 D 54321

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 7 aun ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary. Infussi.

(Residence in Baltimore: No. 922 7 aun St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Infant

6-DATE OF BIRTH. February 20, 1919.
(Month) (Day) (Year)

7-AGE. 2 yrs. 4 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer). Infant

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Infussi

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Rose Amandia

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Infussi

(Address) 922 7 aun St

15-

Filed ..... 1921. Robert P. Harrison, Registrar.

JUN 6 1921 Deputy Health Clerk.

important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 5, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 1921, to June 5 1921, that I saw h.s alive on June 5 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

1 Bronchopneumonia 2 days

Convulsions

(Duration) ....yrs. ....mos. 1 ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ....yrs. ....mos. 17 ....ds.

(Signed) Fred L. Tillalston M. D.

June 6, 1921. (Address) 1038 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincent

DATE OF BURIAL, June 6, 1921

20-UNDERTAKER Wendell Lloyd & Co

ADDRESS 2216 Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54322

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 79

CITY OF BALTIMORE: (No. 1514 Division ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Douglas

(a) RESIDENCE. No. 2218 Booth ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred all his life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Douglas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Barckmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary E. Duglas
(Address) 2218 Booth st

15 Filed JUN 7 - 1921 ROBERT J. BRAITH Registrar
Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 26. 1921. to June 6. 1921. that I last saw h. alive on June 6 1921. and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Chorea (Sydenhams)

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuf-ficiency (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Shackelford M. D.

6/6/1921 Address Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Cathedral	June 9 1921
20 UNDERTAKER	ADDRESS
John Fields	1200 W Fayette

54323

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D 54323

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced Dead a REGISTERED NO. C

CITY OF BALTIMORE (No. Franciscan Sisters Hospital ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Donovan

(Residence in Baltimore: No. 1129 W Fayette St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ... Jan (Month) 5 (Day), 1860 (Year)

7-AGE, 61 yrs. mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Rail Road Man
(b) General nature of industry, business, or establishment in which employed (or employer)..... Baltimore & Ohio

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Cornelius Donahoe

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Sheehan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Donahoe

(Address) 2218 Booth st

15- JUN 7 - 1921 Bond & Leuter Co. Burial Permit Clerk.

Paid ....., 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

about 6 mos.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Faulon M. D.
(Coroner.)

June 7 1921 (Address) 100 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Cathedral	June 9, 1921

20-UNDERTAKER	ADDRESS
John J Fields	1200 W Fayette St

CAUSE OF DEATH important. See instructions on back of certificate.

D 54324

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54324

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 15 - 56

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Ellamont Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis A. Lippold

(a) RESIDENCE. NO. 1801 Ellamont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced (or) HUSBAND of (or) WIFE of Edith P. Lippold

6 DATE OF BIRTH (month, day, and year) Dec 8 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Grocery
(b) General nature of industry, business, or establishment in which employed (or employer) 034
(c) Name of employer

9 BIRTHPLACE (city ~~or town~~) (State ~~or country~~) Cumberland Md

PARENTS

10 NAME OF FATHER Louis Lippold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Albright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna Pa

14 Informant Edith P Lippold
(Address) 1801 Ellamont St

15 FILED JUN 7 - 1921 ROBERT L. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6" 1921

17 I HEREBY CERTIFY, That I attended deceased from May 30" 1921, to June 6" 1921, that I last saw h alive on June 6" 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Delirium Tremens Cardiac Dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Not.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical & Clinical

(Signed) Herbert E. Zepp, M. D.

19 (Address) 3650 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter Paul Cumberland Md	June 8 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons.	1827 N. North Ave

CAUSE OF DEATH. See instructions on back of certificate. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54325

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 848 Orleans St. ST. 14 WARD)

2-FULL NAME Dorothy Elizabeth Gambrill

(a) RESIDENCE. No. 848 Orleans St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] If of foreign birth? yrs. mos. ds.

REGISTERED NO. 104D 54325

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 1920

7 AGE: Years 1 Months 5 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Aa Co Md.

PARENTS

10 NAME OF FATHER: Chancellor Gambrill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Aa Co Md.

12 MAIDEN NAME OF MOTHER: Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Aa Co Md.

14 Informant (Address): A Gambrill 848 Orleans St

15 Filed JUN 7-1921 ROBERT J. BRUTER Registrar Burial permit issued

TION is very important. See instructions.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921 to June 5 1921

that I last saw her alive on June 5 1921

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cholera infantum

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Malnutrition

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinically

(Signed) M D

6/5 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: June 7 1921

20 UNDERTAKER: Jno Goldhagen

ADDRESS: 406 Mary St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-54326

91/110 D 54326

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View St. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aloysius Miller

(a) RESIDENCE. No. 823 S. Dallas St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JUN 7-1921, 19 ROBERT A. KRAUER Registrar

Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1921

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 5, 1921.

that I last saw him alive on June 5, 1921.

and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Ischio-Rectal abscess.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. A. Holden, M. D.

6/6/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	June 7 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Fred'k

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54327

280 D 54327

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 807 N. Dallas ST.: 7 WARD)

2-FULL NAME Elsie Jennison

(a) RESIDENCE. NO. 807 N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single Autumn

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid 070

(b) General nature of industry, business, or establishment in which employed (or employer) Maid

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER Fanthus Foren Hoot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hatie Molock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) born in Baltimore

14 Informant (Address) Mrs Turlen 807 N Dallas St

15 Filed JUN 7-1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4- 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-12-1920, to 6-4-1921, that I last saw h[illegible] alive on 6-3-1921, and that death occurred, on the date stated above, at 5,50 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

Independent

(duration) ..... yrs. 11 mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Gorgill, M. D.

6-6-1921 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL June 7 1921

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Av

TION is very important. See instructions on

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54328

CERTIFICATE OF DEATH.

D 54328

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Miller

(a) RESIDENCE. NO. Sparrows Pt - Md. WARD. Sparrows Pt.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sparrows Point Md.

PARENTS

10 NAME OF FATHER Henry C. Miller

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Amanda Wyatt

13 BIRTHPLACE OF MOTHER (city or town) Essex Co. (State or country) Virginia

14 Informant Henry C. Miller

(Address) Sparrows Pt.

15 Filed JUN 7 - 1921 ROBERT J. BRAUTER Registrar

Burial Permit Issued

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to June 6, 1921, that I last saw her alive on June 6, 1921, and that death occurred, on the date stated above, at 12:20 P.m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) B Macgowan, M. D.

6/6/21 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem	June 7 1921
20 UNDERTAKER Lilly and Zeile	ADDRESS 703 Lwdale St

Magnus Brown

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54329

CERTIFICATE OF DEATH.

D 54329

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 S. Third ST.: 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magnus Brown

(a) RESIDENCE. NO. 125 S. Third ST., 7th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Brown

6 DATE OF BIRTH (month, day, and year) Sept. 12-1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Heimann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Grace Pinieski (Address) 25 S. Third St.

15 Filed JUN 7 - 1921 19 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 5 1921, that I last saw h[illegible] alive on June 5 1921, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Ascending Pulmonary Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Nasopharyngitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) [illegible] M. D.

6/6, 1921 (Address) 3323 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL June 8 1921

20 UNDERTAKER Libby & Zeiler ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH. See instructions on back. THIS is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54330

92-97 D 54330

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO 126 W. Pratt ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Povilas Kiaune

(a) RESIDENCE. NO 126 W. Pratt ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

3a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Alice Kiaune

6 DATE OF BIRTH (month, day, and year) June 29, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Jonas Kiaune

11 BIRTHPLACE OF FATHER (city or town) Lithuania (State or country)

12 MAIDEN NAME OF MOTHER not Known

13 BIRTHPLACE OF MOTHER (city or town) Lithuania (State or country)

14 Informant (Address) Mrs. Alice Kiaune 126 W. Pratt St.

15 Filed JUN 7 - 1921 19 ROBERT J. KRAUTER Registrar

TION is very important. See instructions on back. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 31. 1921. to June 6. 1921. that I last saw him alive on June 6. 1921. and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) John A. Buchness M. D.

, 19 (Address) 650 Columbia ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL June 9 1921

20 UNDERTAKER John Grebliunckas — ADDRESS 425 S Paca St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 54331

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54331

106

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST.: 28 WARD)

2-FULL NAME Mrs Bronslaw Poliznski

(a) RESIDENCE. NO. Mount Hope Retreat ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds How long in U. S., if of foreign birth? Not known. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Mr Poliznski

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
34	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife of Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Not Known Austria

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria (?)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria (?)

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed JUN 7 - 1921, 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1920, to June 6th, 1921, that I last saw her alive on June 6, 1921, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis-

10 days

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Chr. Melancholia

(duration) 6 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

May 6th, 1921 (Address) Mt Hope Retreat Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	June 8 1921

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54332

CERTIFICATE OF DEATH.

151 D 54332

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lynch

(a) RESIDENCE NO. 809 S. Potomac ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2, 1921

7 AGE — Years — Months — Days — If LESS than 1 day, 4 hrs. or — min.

8 OCCUPATION OF DECEASED — 000

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Phern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant E. Riddell. (Address) Johns Hopkins Hospital

15 Filed JUN 7 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Issued

TION is very important. See Instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1921, to June 2, 1921, (that I last saw h[illegible] alive on June 2, 1921, and that death occurred, on the date stated above, at 4:50 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity — 8 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Guy N. Cromwell M. D.

5/4, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL JUN 6 - 1921

20 UNDERTAKER — ADDRESS

Baltimore Health Department 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54333

CERTIFICATE OF DEATH.

152 D 54333

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Pollard

(a) RESIDENCE. NO. 217 N. Bethel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	7	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Ernest Chester.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Grace Pollard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant P. Liddall.
(Address)

15 Filed JUN 7 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1921

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1921, to June 5, 1921, that I last saw h[illegible] alive on June 5, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Intra-cranial hemorrhage
Birth Injury

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 5, 1921

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Guy L. Cromwell, M. D.

6/5, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUN 6 - 1921

20 UNDERTAKER (Commissioner Health.

ADDRESS

Burial permit Sent

TION is very important. See instructions on

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54334

CERTIFICATE OF DEATH.

1891 D 54334

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2242 Linwood Hill ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Diggs

(Residence in Baltimore: No. 2242 Linwood Hill St.: 1 yrs., 7 mos. 30 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	single

6-DATE OF BIRTH, October 5, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 7 mos. 30 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): (none)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Samuel Diggs

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Eliz. Tyler

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sam. Diggs,

(Address) 2242 Linwood Hill

15- JUN 7-1921, 191.... ROBT. J. BAUER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cerebral Congestion
about no day,
(Duration) .... yrs. .... mos. .... ds.
CONTRIBUTORY (Secondary) no history
(Duration) .... yrs. .... mos. .... ds.

(Signed) J. C. H. Hennegan M. D.
(Coroner.)

June 6, 1921 (Address) 2502 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, JUN 7 1921

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST

CAUSE OF DEATH must be stated plainly and accurately. Every item should be answered. Omissions will cause delay. See instructions on back of certificate.

D 54335

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 V D 54335

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2000 Ramsey St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward ~~Henry~~ Fuller

(Residence in Baltimore: No. 2000 Ramsey St.; yrs. 8/12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Aug 7, 1919 (Month) (Day) (Year)

7-AGE, 1 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. —
(b) General nature of industry, business, or establishment in which employed (or employer). —

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Wm H Fuller

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Fuller

13-BIRTHPLACE OF MOTHER (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H. Fuller

(Address) 2000 Ramsey

15- JUN 7 - 1921 191 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. 1 ds.

(Signed) James W Pinkard M. D. (Coroner.)

June 6, 1921. (Address) 1002 Clare St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL New Cathedral Cem. DATE OF BURIAL June 8, 1921

20-UNDERTAKER F C Klipstein ADDRESS 233 Fredk

CAUSE OF DEATH must be filled in. It is important. See instructions on back of certificate.

Cane

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 54336

PLACE OF DEATH

CERTIFICATE OF DEATH

120 ✓ D 54336

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1228 Aisquith St. 10 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Cane

(Residence in Baltimore: No. 1228 Aisquith St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
female	white	Single

6-DATE OF BIRTH ..... unknown ..... (Month) ....., 1 ..... (Day) ..... (Year)

7-AGE ..... 74 ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work ..... Nurse 500
(b) General nature of industry, business, or establishment in which employed (or employer) ..... in family

9-BIRTHPLACE (State or country) Ireland

PARENTS

10-NAME OF FATHER Don't Know

11-BIRTHPLACE OF FATHER (State or country) Ireland

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Fenton

(Address) 700 E. Chase St.

15- Filed JUN 7-1921 ROBERT J. KRAUTER Registrar Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH ..... June ..... 6 ..... (Month) ..... (Day) , 1921 ..... (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 6 1921.

that I saw h-e alive on June 6, 1921.

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Acute Suppurative Cholecystitis

Chronic Interstitial Nephritis (Duration) ..... yrs. ..... mos. 6 ds

Contributory (SECONDARY) two old round ulcers

Sepsis (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Fenton M. D.

June 6, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cathedral — DATE OF BURIAL June 8, 1921

20-UNDERTAKER J. C. Windfield — ADDRESS 917 Gruman

N. B.—Every item should be filled in plain terms, so that it may be properly coded. State CAUSE OF DEATH in plain terms, so that it may be properly coded. Every item is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

15 D 54337

D 54337 CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Gallion

(a) RESIDENCE. NO. 105 Park Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~ yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? ~ yrs. ~ mos. ~ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) June 5th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ~ hrs. or ~ m.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John Henry Gallion

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virgie Jones

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Virginia

14 Informant Virgie Gallion (mother) (Address) 105 Park Ave

15 Filed JUN 7 - 1921 ROBERT I. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5th, 1921 to June 5th, 1921, that I last saw h live on June 5th, 1921, and that death occurred, on the date stated above, at 4:40 P.m.

The CAUSE OF DEATH* was as follows:

Intra Cranial pressure

(duration) ~ yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) Face presentation

(duration) ~ yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? ~ Forceps.

Did an operation precede death? Yes Date of June 5th 1921

Was there an autopsy? Yes.

What test confirmed diagnosis? None

(Signed) J. Morris Reese M. D.

(Address) University Hospital

6-6-1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54338

CERTIFICATE OF DEATH.

40 D 54338

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thompson

(a) RESIDENCE. NO. 17 Taylor St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed JUN 7 - 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1921, to June 3, 1921, that I last saw h.im alive on June 3, 1921, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No special test.

(Signed) B Herman, M. D.

6/4/, 1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	19
20 UNDERTAKER	ADDRESS
Commissioner Health.	

ROBERT F KRAUTER Dental Permit Officer

Per. Wm. E. WOODALL

TION is very important. See instructions on

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54339 CERTIFICATE OF DEATH. X 28 D 54339

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Municipal Tuberculosis Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Robinson

(a) RESIDENCE. NO. Non-resident ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of 1892

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Washington, D.C.

PARENTS

10 NAME OF FATHER Cornelius Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Lucy Roy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records
(Address) M.T.H.

15 JUN 7 - 192 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to June 2, 1921, that I last saw him alive on June 2, 1921, and that death occurred, on the date stated above, at 12.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, T.B. in sputum

(Signed) M. L. Heagney, M. D.

6-2-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	19
20 UNDERTAKER	ADDRESS

TION is very important. See instructions on

6

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54340

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54340

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 S Regester ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina Stelmach

(a) RESIDENCE. No. 412 S Regester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Stelmach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Wladyslawa Kowalski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Stelmach
(Address) 412 S Regester

15 Filed ..... 19 .....
Registrar

NOV 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-25-21, 1921, to June 7, 1921, that I last saw h alive on June 6, 1921, and that death occurred, on the date stated above, at 1A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding.

(Signed) T. F. Kurzrock, M. D.

June 7, 1921 Address 1001 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 8 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

THION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54341

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54341

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 634 W. Lee ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frazier Martin

(a) RESIDENCE. NO. 634 W. Lee ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robt Nickens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susan Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Sophia Martin (Address) 634 W. Lee St.

15 Filed Robert P. Harrison, Registrar

N 7-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1921, to June 5th, 1921, that I last saw her alive on June 4th, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. H. Carwell, M. D.

, 19 (Address) 140 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 8 1921

20 UNDERTAKER John H. Toadvine ADDRESS 147 Hill St

TION is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54342 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54342

28

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 502 W Preston ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Snider

(a) RESIDENCE. NO. 502 W Preston ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER James Dyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Jeanette Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Jeanette Snider
(Address) 502 W Preston

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

NT-1921

TION is very important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1921, to June 4, 1921, that I last saw her alive on June 3, 1921, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Meninges (duration) yrs 1½ mos. ds.

CONTRIBUTORY (Secondary) Phthisis Pulmonalis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operatinn precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H.S. McCard M. D.

6/6, 1921 (Address) 2005 Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peter's

DATE OF BURIAL 6-8 1921

ADDRESS 172 W. Hill St

20 UNDERTAKER John H. Joachim

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54343

D 54343

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1239 Darley Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Krieger

(a) RESIDENCE. NO. 1239 Darley Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. 0 mos. 0 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow.

5a If married, widowed, or divorced (or) WIFE of Mathias

6 DATE OF BIRTH (month, day, and year) May 7- 1846

7 AGE Years 75 Months 0 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) At Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Frank Sonnenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Minnie Knapke (Address) 1239 Darley Ave

15 Filed JUN 7-1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important. See instruction

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1921

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1921, to June 5, 1921, that I last saw her alive on June 4, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Pyelitis

Bronchitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Asthma + Emphysema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation + c

(Signed) Adolph C Eisenberg, M. D.

June 6, 1921 (Address) 1201 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary.

DATE OF BURIAL June. 8 1921

20 UNDERTAKER William Fallsgrave

ADDRESS 114 Eastern Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54344 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 54344

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore and Payson Sts. 40 REGISTERED NO.

CITY OF BALTIMORE: (No. German Aged Home. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria M. Wagner.

(a) RESIDENCE. No. German Aged Home ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Johan Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Margaretha Rubenspatz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria.

14 Informant German Aged Home Records
(Address) Baltimore and Payson Sts.

15 7-1921 Robert F. Harrison, Registrar
. 19
Burial Permit Clerk.

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5. 1920. to June 6th 1921.
that I last saw h.e alive on June 6th 1921.
and that death occurred, on the date stated above, at 12 Noon m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical tests
(Signed) John Hough, M. D.
(Address) 1432 W Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 8' 21
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W Balto St

Spec.—6-9-19—H. P. Co.—1000 Bkn.

D 54345

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54345

64

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2806 Keyworth Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Strohm Sr.

(a) RESIDENCE NO. 2806 Keyworth Ave. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) E. Florence Strohm

6 DATE OF BIRTH (month, day, and year) July 9th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work printing Business

(b) General nature of industry, business, or establishment in which employed (or employer) 063

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Herman F. Strohm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bremen Germany

12 MAIDEN NAME OF MOTHER M. S. Wailes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant (Address) Thomas A. Strohm Jr. 2812 Keyworth Ave.

15 Filed 7-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2 . 1921 . to June 6 . 1921 . that I last saw h ive alive on June 5 1921 . and that death occurred, on the date stated above, at 1145 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis. -

(duration) 4 or 5 yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Bowman Hood . M. D.

6/7 . 1921 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 9 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N Paca St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 54346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-036 D 54346

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 930 Druid Hill Ave. ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvester Richard Coleman

(a) RESIDENCE. NO. 930 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 19 mos. 11 ds. How long in U. S., If of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Blk.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct. 23, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. Sylvester Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alexandria Va.

12 MAIDEN NAME OF MOTHER Augusta Holt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co. Md.

14 Informant (Address) Wm. Sylvester Coleman 930 Druid Hill Ave

15 Filed JUN 8-1921 [illegible] Registrar

Burial permit issued

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to June 6, 1921, that I last saw him alive on June 6, 1921, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Rachitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none except physical signs

(Signed) Burton E. Lapman M. D.

(Address) 2703 Eutaw Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 8 1921

20 UNDERTAKER Daniel Easton

ADDRESS 956 Penna Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

Barton

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 54347

D 54347

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 409 Warren Ave ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Barton

(a) RESIDENCE. NO. 409 Warren Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced (or) WIFE of Ear. Barton

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 57 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) E. E. Barton 409 Warren Ave

15 Filed JUN 8 - 1921 19 BOYER & KRAUTER Burial Permit Issued Registrar

TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 5, 1921, that I last saw h.r alive on June 5, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage.

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) 2 yrs — mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Streett, M. D.

6/7, 1921 (Address) 405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	6/8/21 19
20 UNDERTAKER	ADDRESS
John J. Tabeling & Sons	1818 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54348

CERTIFICATE OF DEATH.

REGISTERED No. D 54348

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Frost (If not over 1 day, St.: yrs., mos. ds.)

(Residence in Baltimore: No. 604 Stump alley)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec (Month) 8 (Day), 1900 (Year)

7-AGE, 20 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Bath City

PARENTS.

10-NAME OF FATHER, Lewis West

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Harriet Hornbeck,

13-BIRTHPLACE OF MOTHER (State or Country), Bath Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irvin West

(Address) 3115 Barclay St

15-JUN 8-1921 Filed, 191 ROBERT J. BRAUER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Alcohol!

(Duration) yrs. mos. ds.

(Signed) H. K. Gorman (Coroner.) M. D.

6/7, 1921 (Address) 117 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, June 18, 1921

20-UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54349

HEALTH DEPARTMENT—CITY OF BALTIMORE

175 — D 54349

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort Mc Henry Baltimore Md. ST. 24 N WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A Parker

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST.. N WARD. Baltimore Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marriet Parker

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mail carrier 086

(b) General nature of industry, business, or establishment in which employed (or employer): US. Post Office

(c) Name of employer: US. Post Office

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER John ~~unknown~~ Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): ~~Unknown~~ Md

12 MAIDEN NAME OF MOTHER Leggie ~~unknown~~ Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Md

14 Informant Edgar T. Rosenbrock Registrar
(Address) US. PHS Hosp. #56 Ft Mc Henry Md.

15 Filed ... 19 ... Registrar

JUN 8-1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 28 1921, 19..., to June 6 1921, 19...,

that I last saw him alive on June 6 1921, 19...,

and that death occurred, on the date stated above, at 2'40 p.m.

The CAUSE OF DEATH* was as follows:

Fracture of both bones of left fore arm.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Surgical Shock

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? yes Date of 6/6 1921

Was there an autopsy? No

What test confirmed diagnosis? Xray Clinic report

(Signed) J. A. Rinehard M. D.

19..., (Address) Surgeon Temp. In Charge US. PHS Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	June 9 1921
20 UNDERTAKER	ADDRESS
Samuel Hemsley	N Bdd St

TION is very important. See instructions on back

UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Mail wagon broke
& threw him which
caused fracture of
arms. Operation to
reset bones.

Spec.—8-24-14—M. & T.—2000 Bks.

54350 HEALTH DEPARTMENT—CITY OF BALTIMORE VD 54350

40

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 Dolphin ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Phyllis Tonney

(Residence in Baltimore: No. 532 Dolphin St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown; ..... (Month) ..... (Day) ..... (Year)

7-AGE, 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Taylor

(Address) 307 Chapelle

15- Rec'd JUN 8 - 1921 191..... ROBERT I KRAUTH Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 7th 1921, to June 7th 1921, that I saw h[er] alive on June 7th 1921, and that death occurred, on the date stated above at 10 P m.

The CAUSE OF DEATH* was as follows:

Influenza

Age (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

Con. Nephritis (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Lee Ellis M. D.

6/7, 1921 (Address) 924 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Zion Cem

DATE OF BURIAL, June 8, 1921.

20-UNDERTAKER Samuel E Handley

ADDRESS 508 N Eutaw St.

important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54351 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 54351

CERTIFICATE OF DEATH.

392

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1643 Gorsuch Ave. ST.: 9 WARD)

2-FULL NAME Samuel L. Stuett

(a) RESIDENCE. No. 1643 Gorsuch ST. Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Catherine Stuett

6 DATE OF BIRTH (month, day, and year) Nov. 12, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	6	25	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Books Keeper 098

(b) General nature of industry, business, or establishment in which employed (or employer) Cocoa Cola

(c) Name of employer C. M. Merrill

9 BIRTHPLACE (city or town) (State or country) Stafford Co. Va.

PARENTS

10 NAME OF FATHER John T Stuett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Stafford Co. Md.

12 MAIDEN NAME OF MOTHER Mary M. Duff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Stafford Co. Maryland

14 Informant Catherine L. Stuett

(Address) 1643 Gorsuch ave.

15 JUN 8-1921 BOWER & KRAUTER Registrar

Burial Permit Must

TION is very important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/27, 1921, to 6/6, 1921, that I last saw h[e] alive on 6-6, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of mouth - Tongue & left tonsil

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Metastatic glands & neck

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam of tissue

(Signed) Dr Bernard Wise M. D.

6/7, 1921 (Address) 914 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 9 1921
20 UNDERTAKER	ADDRESS
Edward W. Conklin	424 E. Eager St.

D 54352

Sheet.—6-9-19—H. P. Co.—1000 Blks.

D 54352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Riverside Ave. WARD 24)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert D. Balse

(a) RESIDENCE. NO. 1009 Riverside Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 5 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Samuel D Balse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Antonett A Bordyno

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Samuel D Blase

(Address) 1009 Riverside Ave.

15 Filed JUN 8-1921 ROBERT I KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1924

17 I HEREBY CERTIFY, That I attended deceased from May 27. 1921. to June 8. 1921.

that I last saw h— alive on June 7. 1921.

and that death occurred, on the date stated above, at 2. A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Apparent 2 days

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Harry L Bucholz, M. D.

19 (Address) 1058 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A. A. Co. DATE OF BURIAL June 9 1924

20 UNDERTAKER John F Denny ADDRESS 715 Light

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 ✓ D 54353

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 517 N. Chester ST.: 7 WARD)

2-FULL NAME Elizabeth Reisenweber

(a) RESIDENCE. NO. 517 N. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late John Reisenweber

6 DATE OF BIRTH (month, day, and year) Jan 22-34

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 700

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER John Lechner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant John Reisenweber
(Address) 517 N. Chester

15 Filed JUN 8 - 1921 ROBERT J. BRAUTER Registrar
Burial permit Oliet

CAUSE OF DEATH in plain words. Do not use abbreviations or technical terms. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 2 1921 to June 6 1921.

that I last saw h[illegible] alive on June 4 1921.

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema
Senile dementia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Gross M. D.

June 8 1921 (Address) 1308 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	June 8 1921

20 UNDERTAKER Philip Herwig ADDRESS 2006 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

Elizabeth Lurman ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

54354

45 D 54354

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. ST.: 11 WARD)

2-FULL NAME Mrs. Gustav Lurman (Elizabeth)

(a) RESIDENCE. NO. 1111 N. Eutaw ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Mr. Gustav Lurman

6 DATE OF BIRTH (month, day, and year) Mar. 9, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland-

PARENTS

10 NAME OF FATHER De Veaux Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Elizabeth Cooke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland-

14 Informant Gustav. W. Lurman

(Address) Catonsville Md.

15 Filed JUN 8- 1921 JUN 8- 1921 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1921

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1921, to June 7, 1921, that I last saw her alive on June 7 1921, and that death occurred, on the date stated above, at 11.57 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas-

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of April 12, 1921

Was there an autopsy? No.

What test confirmed diagnosis? Gross + microscopic pathology

(Signed) H. H. Jamgenbrunn, M. D.

June 7 1921 (Address) U. M. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL June 9 1921

20 UNDERTAKER Howard Jenkins Sons Co. — ADDRESS Tuscullo & Orchard

TION is very important. See instructions on back

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54355

CERTIFICATE OF DEATH.

64 ✓

D 54355

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1244 S Decker Ave ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Kordonski

(Residence in Baltimore: No. 1244 S Decker Ave

S[illegible] yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Feb. (Month) 12 (Day), 1872 (Year)

7-AGE. 49 yrs. 3 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Wawzen Kordonski

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Michalina Micinska

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Mrs Kordonski (Informant)

1244 S Decker Ave (Address)

15- Filed JUN 8 - 1921 191... [illegible] Registrar.

Burial Permit Obtd

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

6/7, 1921 (Signed) Thomas Synan M. D. (Address) 1800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

18-PLACE OF BURIAL OR REMOVAL, St Johns Plane Cem

DATE OF BURIAL, June 9, 1921

20-UNDERTAKER Stephen Kwiatkowski

ADDRESS Wood & Kennedy ave

CAUSE OF DEATH must be stated plainly and fully. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54356

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54356

CERTIFICATE OF DEATH.

REGISTERED NO. C 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Finnyon Harriet Merican

(Residence in Baltimore: No. 726 N. Broadway St.; yrs., 4 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, Feb. (Month) 4 (Day), 1917 (Year).

7-AGE, ...yrs. 4 mos. 3 da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Charles Merican

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Mollie Fuchs

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Baltimore

15- BURIAL PERMIT ISSUED JUN 8 - 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 7 (Day), 1921 (Year).

I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to June 7, 1921

that I saw her alive on June 7, 1921

and that death occurred, on the date stated above, at 6:15 P.

The CAUSE OF DEATH* was as follows:

Cholera

(Duration) ....yrs. ....mos. 1½ ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) ....yrs. ....mos. 6 ds.

(Signed) Louis Jacks M. D.

June 7, 1921 (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 8 ds. In the State ....yrs. 4 mos. 3 ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 726 N Broadway

19-PLACE OF BURIAL OR REMOVAL. Hebrew Mash Road

DATE OF BURIAL. 6/8, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

important. See instructions on back of certificate

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54357

118

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hosp. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Douglas

(a) RESIDENCE. NO. 18 E. Wadsford Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Douglas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Tuetter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Fanny Douglas
(Address) 1818 Hanford Ave.

15 [illegible] JUN 8 - 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to June 6, 1921, that I last saw h[illegible] alive on June 6, 1921, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis (Acute Appendicitis)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Appendicitis (chronic)

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

June 6 1921 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	June 9 1921
20 UNDERTAKER Geo. J. Rutter.	ADDRESS 1735 Hanford Ave.

TION is very important. See instructions on this

Spec.—8-24-14—M. & T.—2000 Bks.

Schwarz

HEALTH DEPARTMENT—CITY OF BALTIMORE

150

D 54358

D 54358

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 1 west on Belair Rd ST. No 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Mrs.) Emma Schwarz (Wife or Widow of Geo. F. Schwarz)

(Residence in Baltimore: No. No 1 west Belair Ave St.; — yrs., — mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Wid

6-DATE OF BIRTH, June (Month) 7 (Day), 1849 (Year)

7-AGE, ...yrs. 1 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Ø)

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Mr Schwarz

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Grace Courtlen

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Schwarz

(Address) 1 No 1 West Ave

15- Filed JUN 8 - 1921 ROBERT J. KRAUTER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7 1921, to June 8 1921, that I saw her alive on June 7 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

Edema

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas Bruns M. D.

June 8, 1921. (Address) 2706 Harford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Jerusalem Cemetery

DATE OF BURIAL, June 8th, 1921

20-UNDERTAKER George F. Rutt

ADDRESS 1735 Hayford Ave

important. See instructions on back of certificate

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 ✓ D 54359

CERTIFICATE OF DEATH.

REGISTERED NO.

D 54359

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2221 E Chase St.: 8 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Francis Hornberger

(a) RESIDENCE. No. 2221 E. Chase St St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21- 1890

7 AGE — Years: 31 — Months: 4 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John W Hornberger Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary E Lewellen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): John W Hornberger Sr 2221 E Chase

15 Filed JUN 8 - 1921 LOUIS H. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May, 1919, to May, 1921, that I last saw him alive on June 1, 1921, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute fatal Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

1921 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (Use reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rollers Cem. — DATE OF BURIAL: June 9 1921

20 UNDERTAKER: Robt Turner Sr — ADDRESS: 1xx 22 May

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54360 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54360

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 E Federal ST.; 8 WARD)

2-FULL NAME Johanna Steugler

(a) RESIDENCE. No. 1514 E Federal ST., WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 ~~Single, Married, Widowed,~~ or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Steugler

6 DATE OF BIRTH (month, day, and year) Epiphany

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ferd Etzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Kohler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas Steugler Husband

(Address) 1514 E Federal St

15 Filed JUN 8 - 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1921

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1921, to June 7, 1921, that I last saw h[illegible] alive on June 7, 1921, and that death occurred, on the date stated above, at 11 30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Hypertrophied Prostate

(duration) yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) David Muller, M. D.

19 (Address) 1506 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 10 21
20 UNDERTAKER	ADDRESS
Geo. T. Zumer	1424 Bway

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54361

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54361

CERTIFICATE OF DEATH.

120 V

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 N. Mount St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Lucy E. Catterton

(Residence in Baltimore: No. 1006 N. Mount St.; Unknown yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 10 (Day), 1840 (Year)

7-AGE, 81 yrs. 1 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Henry Burch

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Emma Newbill

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Otto Burkhardt

(Address) 1006 N. Mount St.

15- Filed JUN 8-1921, 191... ROBERT J. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 12 1921, to June 7 1921, that I saw her alive on June 7 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Acute~~ Pneumonia, Lobar

(Duration) yrs. 7 mos. ds.

(Signed) Wm. E. Stadtfeld M. D.

June 7 1921 (Address) 735 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Loudon Pk Cem

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Chas. J. Evans & Son

ADDRESS 115 N. Howard St

Important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54362 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54362

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 Beaumont Ave - ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mae Heipsley

(a) RESIDENCE. NO. 802 Beaumont Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	married.

5a If married, widowed, or divorced (or) WIFE of Oscar Hipsley.

6 DATE OF BIRTH (month, day, and year) Feb. 1st. 1883

7 AGE 38	Years	Months 7	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James E. Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lydia A. Blatchley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Oscar Hipsley (Address) 802 Beaumont Ave

15 Filed Robert P. Harrison, Registrar

JN 8-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25 1921, to June 7th 1921, that I last saw h[illegible] alive on June 7th 1921, and that death occurred, on the date stated above, at 12 M. P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 802 Beaumont Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. C. Bose, M. D.

, 19 (Address) 1923 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cem	June 9 21
20 UNDERTAKER John Burns Sons	ADDRESS Towson

TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54363

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3352 Hickory Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Harris

(a) RESIDENCE. No. 3352 Hickory Ave. ST., 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. + mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence M. Harris

6 DATE OF BIRTH (month, day, and year) Dec. 28-1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Maryland

PARENTS

10 NAME OF FATHER John Henry Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Eliza Hampshire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant (Address) Mrs. Florence M. Harris 3352 Hickory Ave

15 Filed JUN 8-1921 Robert T. Harrison, Registrar

Burial Permit Issued

TION is very important. See INSTRUCTIONS on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7- 1921

17

I HEREBY CERTIFY, That I attended deceased from April, 1920, to June 7, 1921, that I last saw him alive on June 7, 1921, and that death occurred, on the date stated above, at 3 1/2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6/7. 1921 (Address) 2020 N. Chapel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	June 10. 1921
20 UNDERTAKER Horace H. Burgee	ADDRESS 363 Falls Rd.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54364

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 531 N. Fremont ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ryan

(a) RESIDENCE. NO. 531 N. Fremont ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Ryan

6 DATE OF BIRTH (Month, day, and year): [illegible] 1871

7 AGE — Years: 50 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Christie Carney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Fredk. Schmuck

(Address): 531 N. Fremont Ave

15 Filed 6-8-1921 Robert P. Harrison, Registrar

Burial Permit Given

TION is very important. See INSTRUCTIONS on back of

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 21st 1919, to June 7th 1921, that I last saw h[illegible] alive on June 7th 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yr. 7 mos. — ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? 817 George St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriology

(Signed) Wm J Thompson, M. D.

6/8, 1921 (Address) 1701 N. Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 10 1921

20 UNDERTAKER: Robt S. Little — ADDRESS: 2710 Edmondson Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 54365

CERTIFICATE OF DEATH.

D 54365

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1342 Stockton ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edward Johnson

(a) RESIDENCE. No. 1342 Stockton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~May~~ 5-7-14 May 8 1914

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Prince Edw. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co., Va

12 MAIDEN NAME OF MOTHER Lelia F. Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co. Va.

14 Informant Mary C. Cryor

(Address) 1346 Stockton St.

15 FILED JUN 9- 1921 ROBERT I. KRAUTER Registrar Burial Permit Dist.

TION is very important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-5- , 1921, to 6-8- , 1921, that I last saw h alive on 6-7- , 1921, and that death occurred, on the date stated above, at 12.50 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac asthenia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia (Lobar)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5-31-21.

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) George C. Page, M. D.

, 19 (Address) 1720 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	June 10 1921
20 UNDERTAKER James H. Dennis	ADDRESS 1350 Pennsylvania Ave

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54366

CERTIFICATE OF DEATH.

28 D 54366

REGISTERED NO.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST., 34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Pollard

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., Baltimore Md. (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1898 unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 67

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T Rosenbrock Registrar

(Address) US. PHS Hosp. #56 Ft McHenry Md.

15 Filed JUN 9 - 1921 ROBERT J. BRUTEN Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19 1921 to June 6 1921 . 19 .

that I last saw him alive on June 6 1921 . 19 ,

and that death occurred, on the date stated above, at 5'25 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary adv. active

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam Clinic report

(Signed) J. B. Rueckard M. D.

P.A. Surgeon

, 19 (Address) US. PHS Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL national Cem DATE OF BURIAL JUN 9 1921

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54367

151 D 54367

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Miller

(a) RESIDENCE. NO. 4708 Harford (Lauraville) ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	1	2

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

800

9 BIRTHPLACE (city or town) (State or country) St Josephs Hospital

PARENTS

10 NAME OF FATHER Palmer W. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Laney A. Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Palmer W. Miller
(Address) 4503 Weitzel ave.

15 Filed JUN 9- 1921 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/8/1921

17 I HEREBY CERTIFY, That I attended deceased from 6/6/, 1921, to 6/8/, 1921,
that I last saw h[illegible] alive on 6/8/, 1921,
and that death occurred, on the date stated above, at 11 a.m.
The CAUSE OF DEATH* was as follows:

Prematur Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C-C Smith, M. D.

, 19 (Address) 4706 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emanuel Cemetery Lauraville Md	June 9 1921

20 UNDERTAKER George J. Smith ADDRESS 1000 N Gay St

TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54368

CERTIFICATE OF DEATH.

X 74 D 54368

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 N Ewlan Place ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina J. Erdmans

(a) RESIDENCE. No. 1529 N Ewlan Place ST., WARD. Miami Fla

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chicago Ill

PARENTS

10 NAME OF FATHER Robert H Erdmans

11 BIRTHPLACE OF FATHER (city or town) Holland (State or country) Netherlands

12 MAIDEN NAME OF MOTHER Hattie Efting

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Netherlands

14 Informant Mrs Hattie Erdmans

(Address) 742 2nd st N W Miami Fla

15 JUN 9 1921 Burial ... Registrar

TION is very important. See instruction

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17 I HEREBY CERTIFY, that I attended deceased from Nov. 1, 1920, to June 8, 1921, that I last saw her alive on June 8, 1921, and that death occurred, on the date stated above, at 7 10 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Florida

Did an operation precede death? Yes Date of July 16, 1918

Was there an autopsy? No

What test confirmed diagnosis? Hours dies - Lumbar puncture

(Signed) Dudley A Corbett, M. D.

19 (Address) 1418 Eaton Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Miami Florida	June 9 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 W North Ave

Sporer

D 54369 HEALTH DEPARTMENT—CITY OF BALTIMORE V 004

D 54369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp St. 8 WARD) 175 - 9

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Simon Sporer

(Residence in Baltimore: No. 2039 E Oliver St.; yrs., mos., ds.)

prisoner - also somewhere in Canada

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE. 42 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.? 3 26

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Worked in
(b) General nature of industry, business, or establishment employed (or employer) Mfr Dairy 086

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. H Sporer

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Arnold

13-BIRTHPLACE OF MOTHER (State or Country). 2039 E Oliver Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H Sporer

(Address) 2039 E. Oliver

15 Filed JUN 9 - 1921, 191.. ROBERT J. KRAUTER Registrar.

Burial Permit Issued

CAUSE OF DEATH must be given. It is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Shot wound - homicide

Shot wound (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cemetery

DATE OF BURIAL. June 10, 1921.

20-UNDERTAKER Neely Hirsch Co.

ADDRESS 1001 E Eager St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 54370

D 54370

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N Pine ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Whittington

(Residence in Baltimore: No. 213 N Pine St.; Auburn yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Last Known (Month) (Day) about 1837 (Year)

7-AGE, 84 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None 000
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). St Louis Mo

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah M Whittington (wife)

(Address) 213 N. Pine St.

15- Filed JUN 9 - 1921 191.. [illegible] Burial Permit Issued

Important. Use Indelible Pencil.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 6th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25 1921, to June 6th 1921, that I saw him alive on June 6th 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) yrs. mos. 10 ds.

(Signed) Frank M Glennon M. D.

June 7, 191.. (Address) 332 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Mt Auburn Ct

DATE OF BURIAL. June 9, 1921

20-UNDERTAKER J. L. & J. Brown & Son

ADDRESS 10 W Mulberry St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54371

CERTIFICATE OF DEATH.

92-004 D 54371

1-PLACE OF DEATH

CITY OF BALTIMORE; No. 1305 N. Ostend ST.; 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Bailey

(a) RESIDENCE No. 1305 N. Ostend ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Bailey

6 DATE OF BIRTH (month, day, and year): March 18? 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59.	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer): B & O. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New London. Connecticut

PARENTS

10 NAME OF FATHER: George F. Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Connecticut

12 MAIDEN NAME OF MOTHER: Johannah Losey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Connecticut

14 Informant: Frieda Mabel (Address) 1305 N. Ostend St.

15 JUN 9 - 1921 [redacted] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 24 1921, to June 8 1921, that I last saw him alive on June 8 1921, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

8-6, 192 (Address) 602 Columbia ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 11 1921

20 UNDERTAKER: Mrs. Mrs. John W. Teufel & Son ADDRESS: 801 W. Fayette

TION is very important. See instructions on back of certificate.

D 54372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54372

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 922 Jordan alley ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Thomas

(Residence in Baltimore: No. 922 Jordan alley St.; 36 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, unknown (Month), (Day), 1883 (Year)

7-AGE, 38 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) General

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Richard Adams

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Lillie Blake

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Gray

(Address) 705 N. Biddle St.

15- Filed JUN 9- 1921 19.. ROBERT I. KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the date stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) chronic alcoholism

(Duration) yrs. mos. 3 da.

(Signed) J. J. Hennessy M. D.
(Coroner.)

June 9, 1921 (Address) 2502 Jamison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, 6/10/21 19..

20-UNDERTAKER Mrs R A Elliott

ADDRESS 1728 Eastland

CAUSE OF DEATH must be given. Information is important. See instructions on back of certificate.

Spec.—4-9-19—H. P. Co.—1000 Blks.

D 54373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54373

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 McRoyal Ter ST. 14 WARD)

2-FULL NAME Charles Taylor Brown

(a) RESIDENCE. NO. 1906 McRoyal Ter ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura H Brown

6 DATE OF BIRTH (month, day, and year) Apr 7, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Bronze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliza Jane McClure

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John H Brown (Address) 201 Redgewood Rd

15 JUN 9 - 1921 ROBERT J. KRAUTER Registrar

Burial permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 19. 1921. to June 8. 1921. that I last saw him alive on June 8. 1921. and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Gen. Arterio-sclerosis

(duration) Several yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No. —

What test confirmed diagnosis? —

(Signed) Justice F. Robinson, M. D.

6/9, 1921 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	June 10, 1921

20 UNDERTAKER John O Mitchell ADDRESS 1201 W Fayette St

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54374

D 54374

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2571 Frederick Ave ST. 40 WARD)

2-FULL NAME Walter P Durham

(a) RESIDENCE. NO. 2571 Frederick Ave ST. 40 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. 21 ds. How long in U. S., if of foreign birth? — yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER C A Durham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary E Haupt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mary E Durham

(Address) 2571 Frederick Ave

15 Filed JUN 9 — 1921 19 [illegible] Registrar

[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7/21 19

17 I HEREBY CERTIFY, That I attended deceased from Mar. (?) 1920, to Jun 6 — 1921.

that I last saw him alive on Jun 2 — 1921.

and that death occurred, on the date stated above, at 11.50 p. m.

The CAUSE OF DEATH* was as follows:

Cachexia

CONTRIBUTORY (Secondary) duration yrs. 2 mos. ds.

(duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home of deceased

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E M Dorsey M. D.

1921 (Address) 1502 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 10 1921

20 UNDERTAKER ADDRESS

F B Kuppert 2244 Frederick Ave

TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54375

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54375

CERTIFICATE OF DEATH.

8091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 Bank ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie C. Ross.

(a) RESIDENCE. NO. 2114 Bank ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. 001

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Herschell Ross.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Simms.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Herschell Ross. (Address) 2114 Bank St.

15 Filed JUN 9- 1921 Registrar

TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from May. 28. 1921, to June. 8. 1921, that I last saw he alive on June 8. 1921, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Whooping Cough.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Herbert C. Blake, M. D.

June 9. 1921 (Address) 60 (4W Fo Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 9 1921
20 UNDERTAKER	ADDRESS
Wendell Appelson	37 S. Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 54376

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 W. Hamburg ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Parks

(a) RESIDENCE. NO. 219 W. Hamburg ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moses Parks

6 DATE OF BIRTH (month, day, and year) Sept. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Nelson Co., Va.

PARENTS

10 NAME OF FATHER Sterling Nunery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nelson Co. Va.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Moses Parks (Husband)
(Address) 219 W. Hamburg St

15 Filed JUN 9—1921 19 ROBERT J. BRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7" 1921

17 I HEREBY CERTIFY, That I attended deceased from May 22" 1921, to June 6" 1921, that I last saw h. alive on June 6" 1921, and that death occurred, on the date stated above, at 5.50 A m.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism

Abortion duration yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Shelton, M. D.

19 (Address) 203 W. Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL June 9 1921

20 UNDERTAKER R. S. Parham

ADDRESS 649 W. Lee St.

TION is very important. See instructions on back of

Form — 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54377 — 79 D 54377

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1540 McCulloh ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Cooper

(a) RESIDENCE. NO. 1540 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col'd	Widd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer: Married

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Chas Thornton

(Address): 1540 McCulloh St

15 Filed JUN 9-1921 ROBT. J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to June 8, 1921, that I last saw h alive on June 5, 1921, and that death occurred, on the date stated above, at 12 1 m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Tuberculosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? N

Did an operation precede death? N Date of N

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Moorman, M. D.

June 9 1921 (Address) 1539 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 11 1921
20 UNDERTAKER: John A Owens	ADDRESS: 538 Ralph

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54378

CERTIFICATE OF DEATH.

HV D 54378

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3017 Garrison Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) (Resident)

2-FULL NAME Isabel Wilson Schneider

(a) RESIDENCE. No. 3017 Garrison Ave ST., 15 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? 58 yrs. 8 mos. 14 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles B Schneider

6 DATE OF BIRTH (month, day, and year) Sept 24 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James A Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Belfast Ireland

12 MAIDEN NAME OF MOTHER Amelia Folke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Isabel H. Schneider
(Address) 3017 Carrison ave

15 Filed JUN 9 - 1921 ROBERT I. FOSTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 21, 19..., to June 7, 1921, that I last saw h[illegible] alive on June 7, 1921, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 1 21

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

June 9, 1921 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: June 9/ 1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54379

CERTIFICATE OF DEATH.

120

D 54379

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 N Bond st ST.; 6 WARD)

2-FULL NAME Louis Zuskin

(a) RESIDENCE. NO. 218 N Bond st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sprinza Zuskin

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glazier 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Zuskin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Zuskin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1711 E Baltimore st

15 Filed JUN 9-1921 ROBERT I. LEATER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/9 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3 1921, to June 9 1921, that I last saw h— alive on June 3 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arteriosclerosis Dysentery.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) A. Flax, M. D.

June 9 1921 (Address) 24 N Bond st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 6/9 1921

20 UNDERTAKER Jack Lewis

ADDRESS 1711 E Baltimore st

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 54380

D 54381

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1931 E Balt St ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Lyons

(a) RESIDENCE. NO. 1931 E Balt St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Lyons

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE — Years: 70 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1411 E Balt St

15 Filed JUN 9- 1921 ROBERT F. [illegible] Registrar

Burial Permit Clerk

TION is very important. See instructions on back of C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1 1921, to June 8 1921, that I last saw her alive on June 8 1921, 2 P. m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas J Block M. D.

6-9, 1921 (Address) 1012 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery Rms

DATE OF BURIAL: 6/9 1921

ADDRESS

20 UNDERTAKER: Jack Lewis 1411 E Balt St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54381

HEALTH DEPARTMENT—CITY OF BALTIMORE

69

D 54381

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella V. Brown

(a) RESIDENCE. No. Mt Hope Retreat ST. 28th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 17-1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Wm P. Brown

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Cawley

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Balto Md

15 [illegible] ISSUED

JUN 9 1921

Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 20 1921 to June 7th 1921 that I last saw h 42 alive on June 6th 1921 and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Epilepsy - Status Epilepticus -

abt (duration) 0 yrs. 0 mos. 18 ds.

CONTRIBUTORY (Secondary) Epileptic Mania -

Dont Know (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Baltimore Md

Did an operation precede death? d no Date of

Was there an autopsy? d no

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

June 7th 1921 (Address) Frank J Flannery.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 10th 1921
20 UNDERTAKER	ADDRESS
John J Bowan & Son	901 Hollins St

TION is very important. See instructions on back of

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 54382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54382

45

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1915 Hanover ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Scheckels

(a) RESIDENCE. NO. 1915 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza A Scheckels

6 DATE OF BIRTH (month, day, and year) Oct 23 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work B & O 073

(b) General nature of industry, business, or establishment in which employed (or employer) Employee

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Henry Scheckels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Hively

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Eliza A Scheckels 1915 Hanover St

JUN 9 1921 [illegible] Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from May 3 . 1921 . to June 8 . 1921 .

that I last saw him alive on June 8 1921.

and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma OVRY

(duration) 4 mos. 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes (Date of) April 24.

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Wm Thayer, M. D.

, 19 (Address) 1215 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: June 11 1921

20 UNDERTAKER: JOHN F. DENNY

ADDRESS: 716 LIGHT ST.

TION is very important. See instructions on back of

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Originated in Bladder

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54383

54383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 832 William St. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel L. Johnson

(a) RESIDENCE. NO. 832 William ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 18 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Boiler Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Samuel C. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Mary E. Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant: John L. Johnson
(Address) 832 William St

JUN 9 1927 [illegible] Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 18t, 1921, to June 7, 1921, that I last saw him alive on June 7, 1921, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Hammond Lee M. D.

June 8, 1921 (Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	June 10 1921
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

TION is very important. See instructions on back of

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Nephritis

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Mueller)

D 54384 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54384

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Bruce ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno Mueller

(a) RESIDENCE. NO. 1013 Bruce ST., 21 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Mueller

6 DATE OF BIRTH (month, day, and year): April 13. 1850

7 AGE: Years 71 Months 1 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Presb. Church

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jno Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jno Braun

(Address) 1013 Bruce

15 [illegible]

JUN 9- 1921

Burial Permit [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1921, to June 7, 1921

that I last saw him alive on June 7, 1921

and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) [illegible] M. D.

, 19 (Address) 1130 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 10 1921

20 UNDERTAKER: E J Finnerty — ADDRESS: 46 Dulaney

TION is very important. See instructions on back

Spec. 6-9-19—H. P. Co.—1000 Bks.

148693 D 54385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54385

CERTIFICATE OF DEATH.

14

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Cegielski

(a) RESIDENCE. NO. 521 Alicanda St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Fifty mos. ds. How long in U. S., if of foreign birth? 5 yrs. 8 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male.	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 916.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER Lawrence Cegielski

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Anna Kochinack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUN 9 1921 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7. 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7. 1921, to June 7. 1921, that I last saw him alive on June 7. 1921, and that death occurred, on the date stated above, at 1145 P m.

The CAUSE OF DEATH* was as follows:

Bacillary dysentery

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Widdison, M. D.

6-5, 1921 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	June 10 1921
20 UNDERTAKER M. F. Sadowski	ADDRESS 705 E. Ann

TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54386

CERTIFICATE OF DEATH.

55,001

D 54386

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 17 WARD)

2-FULL NAME William Hartzell

(a) RESIDENCE. NO. 408 E 27th ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15 '07

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Jacob Hartzell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER May Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Jacob G Hartzell
(Address) 408 E 27th St.

15 Filed JUN 9th 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17

I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to June 8, 1921,

that I last saw h[illegible] alive on June 7, 1921,

and that death occurred, on the date stated above, at 24 m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Asthenia.

(duration) yrs. mos. 7, ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys. Findings.

(Signed) L. D. Bosagno, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn [illegible] DATE OF BURIAL: June 10th 1921

20 UNDERTAKER: Robt J Jones Bro ADDRESS: 1422 Pa Ave

THIS IS very important. See instructions on reverse side.

D 54387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54387

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) Corner of W. Cold Spring Lane and Greenmount Ave ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Soden

(Residence in Baltimore: No.) 56 Annapolis Ave Mt Hamden St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, November, 1886
(Month) (Day) (Year)

7-AGE, 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer
(b) General nature of industry, business, or establishment in which employed (or employer), Odd

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Chas. M. Soden

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Mary Frankland

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellsworth Hill

(Address) Mt. Hamden, Md.

15- JUN 9 - 1921 Filed, 191.. Burial Permit Issued

ROTHERT & FRAUTEN Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Hypertrophy heart disease
Dropped dead
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) no history
(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)
June 9 1921 (Address) 280 E. Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn — DATE OF BURIAL, June 8, 1921

20-UNDERTAKER Edw. Ruggold — ADDRESS 1463 Carey St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1920 22.

D 54388

CERTIFICATE OF DEATH.

28D 54388 891

1-PLACE OF DEATH U.S. Public Health Hosp. #56 Fort McHenry Baltimore Md. 24 WARD)

CITY OF BALTIMORE: (NO.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William T West

(a) RESIDENCE NO. US. Public Health Hosp. #56 Fort McHenry Baltimore Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Reita M West

6 DATE OF BIRTH (month, day, and year) DEC 1891

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
29yrs	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bulter 070
(b) General nature of industry, business, or establishment in which employed (or employer) Soldier
(c) Name of employer - -

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Clemind West

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Md

12 MAIDEN NAME OF MOTHER unknown Matt West

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) Md

14 Informant Edgar T Rosenbrock Registrar
(Address) US. PHS Hosp. #56 Ft McHenry Md.

15 Filed Robert P. Harrison Registrar

9-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921 19

17 I HEREBY CERTIFY, That I attended deceased from July 2 1921 to June 8 1921 19
that I last saw h in alive on June 8 1921 19
and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:
Tuberculosis chronic pulmonary mod. adv. active

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) ---
(duration) .. yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Exam Clinic report

(Signed) J. D. Reichard M. D.
P.A. Surgeon
19 (Address) US? PHS Hosp. #56 Ft Henry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL June 11 1921

20 UNDERTAKER Hamme Eddington ADDRESS 36 Fremont

CAUSE OF DEATH. ATTENTION is very important. See instructions on back of certificate.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

D 54389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54389

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf. ST.: 11 WARD)

2-FULL NAME Mr. Duncan B. Clark.

a) RESIDENCE. No. 803 Park ave ST., WARD. 2

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan" 4th 1845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	5	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work retired minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

018

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Michael M. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ann M. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Asst Supt

15 Filed 6-9-1921 Robert P. Harrison, Registrar
Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1921, to June 8, 1921, that I last saw h alive on June 8, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 10? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? auscultation

(Signed) W.D. Noble per H.H.Garrett, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Forest	6-10 1921
20 UNDERTAKER	ADDRESS
Henry W. Jenkins Sons Co.	Orchard & McCulloh

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54390 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54390

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Hanover ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Frank

(a) RESIDENCE. No. 1225 Hanover ST., 23rd WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Frank.

6 DATE OF BIRTH (month, day, and year) DEC. 22 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Nicholas A Frank

(Address) 1225 Hanover St

15 Filed JUN 9 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 23rd, 1921, to June 9th, 1921.

that I last saw h[illegible] alive on June 8th, 1921.

and that death occurred, on the date stated above, at 2 40 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis and Chronic Aortic Incompetency of Heart (duration) — yrs. 3 yr. 14 ds.

CONTRIBUTORY (Secondary) Acute Oedema of Lungs (duration) — yrs — mos. 1/2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Heibel, M. D.

6/9, 1921 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Monroe Meth	6-10-1921
20 UNDERTAKER	ADDRESS
E + B Hale	115 E Hoff Pr

Spec.—8-24-14—M. & T.—2000 Bks.

D 54391

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54391

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 N. Carey ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julianna C. Gloatzky

(Residence in Baltimore: No. 1719 N. Carey St. St.; — yrs., — mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May 29, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Franklin Square Hospital

PARENTS.

10-NAME OF FATHER, Charles Edward Gloatzky

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Julianna Muellhan

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Edward Gloatzky

(Address) 1719 N. Carey St.

15- Robert P. Harrison,

Filed JUN 9 1921, 191.... Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7, 1921, to June 8, 1921, that I saw her alive on June 8, 1921, and that death occurred, on the date stated above, at 9:50 p.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) "Cold"

(Duration) ....yrs. ....mos. 2 ds.

(Signed) C. T. Dickey M. D.

June 8, 1921. (Address) 14 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery DATE OF BURIAL, June 11, 1921

20-UNDERTAKER Geo. J. Smith ADDRESS 2200 W. Lafayette Ave

Important. See instructions on back of

(Concealed hemorrhage. Child was haemophiliac. Cause of hemorrhage unknown. Not diphtheretic)

Spec.—6-9-19—H.P. Co.—1000 Bks.

D 54392

D 54392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hospital ST.: 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Frederick Wohlgemuth.

a) RESIDENCE. NO. 1111 Curtis Ave Curtis Bay, Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22-20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Curtis Bay. Md.

PARENTS

10 NAME OF FATHER Louis Wohlgemuth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Daneker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant. Louis Wohlgemuth.
(Address) Curtis Bay Md.

15 Filed ..... 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

N 9-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1921, to June 8, 1921, that I last saw h/m alive on June 8, 1921, and that death occurred, on the date stated above, at 10:N P. m.

The CAUSE OF DEATH* was as follows:

Int. Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Catarrhal Laryngitis.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Isaac Finglass M. D.

, 19 (Address) Nursery & Child's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 10 1921

20 UNDERTAKER George J Smith ADDRESS 1000 N. Fayette.

TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Original)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 54-55

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hospital ST., WARD)

2—FULL NAME George Frederick Wohlgemuth

(a) RESIDENCE NO. 1141 Curtis Ave, ST., WARD 11 (If non-resident give city or town)

(Usual place of abode) Curtis Bay Md.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Curtis Bay, Md

PARENTS

10 NAME OF FATHER Louis Wohlgemuth

11 BIRTHPLACE OF FATHER (city or town) ....
(State or country)

12 MAIDEN NAME OF MOTHER Mary Danneker

13 BIRTHPLACE OF MOTHER (city or town) ....
(State or country)

14 Informant ....
(Address)

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June

17 I HEREBY CERTIFY, That I attended d
June 7 ....., 1921, to June
that I last saw h... alive on June 8
and that death occurred, on the date stated above, at 0
The CAUSE OF DEATH was as follows:

Int. Hemorrhage

(duration) yrs. mo

CONTRIBUTORY (Secondary) Acute Otorrhea

(duration) yrs. mo

18 Where was disease contracted if not at place of death? No

Did an operation precede death? ..... Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ....

, 19 (Address) 2062 E. Pratt S

*State the Disease Causing Death, or in deaths from Viole
state (1) Means and Nature of Injury, and (2) whether
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE O

20 UNDERTAKER — ADDR

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54393

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54393

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Powers

(a) RESIDENCE. No. Unknown ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John Powers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Benton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant (Address): Hospital Records. New City Hospital.

15 Filed JUN 9- 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1921, to June 8, 1921, that I last saw h im alive on June 7, 1921, and that death occurred, on the date stated above, at 4:50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary abscess, non-tuberculous.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Brain tumor.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 2-24-21.

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) R. H. Harrison M. D.

6/8/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 13 1921

20 UNDERTAKER: George J Smith ADDRESS 1000 Fayette st

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54394 HEALTH DEPARTMENT—CITY OF BALTIMORE 28 D 54394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2001 Belair Ave, St.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcella Dudek

(a) RESIDENCE. No. 3126 Barwood Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Paul Dudek

6 DATE OF BIRTH (month, day, and year): June 15 1893

7 AGE: Years 28; Months 11; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): Good

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Andrew Zelenesky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Barbara Krisnia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Mrs Dudek 3126 Barwood Ave

15 Filed JUN 9-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1921, to June 8, 1921, that I last saw her alive on June 7, 1921, and that death occurred, on the date stated above, at 4:00 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tuberculosis

(Signed) D. Wurmser M. D.

6-9 19 21 (Address) 1001 N Belt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery

DATE OF BURIAL: June 10 1921

20 UNDERTAKER: Frank A Groh Son

ADDRESS: 1406 N Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54395

CERTIFICATE OF DEATH.

D 54395

109

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 404 N Bunley ST.; 6 (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Vajda

(a) RESIDENCE. NO. 407 N Bunley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria Vajda

6 DATE OF BIRTH (month, day, and year): Dont know

7 AGE — Years: About 69 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: At Home

11 BIRTHPLACE OF FATHER (city or town) (State or country): At Home

12 MAIDEN NAME OF MOTHER: At Home

13 BIRTHPLACE OF MOTHER (city or town) (State or country): At Home

14 Informant: Mary Vajda
(Address) 407 N Bunley St

15 Filed ..... 19 Robert P. Harrison, Registrar

JUN 9-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1921, to June 8, 1921, that I last saw h— alive on June 8, 1921, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
Volvulus. Strangulated Hernia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY * (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. J. Rowe, M. D.
6/8/21 (Address) 804 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 11 1921

20 UNDERTAKER: Ernest Evans — ADDRESS: 1906 Eutaw

TION is very important. See instructions on back of

Spec.—1-24-14—M. & T.—2000 Bks.

D 54396 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54396

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 65-4 Josephine ST.; WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. Robt-Blake
(Residence in Baltimore: No. 65-4 Josephine St.; 1 yrs., 3 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M | 4-COLOR OR RACE, C | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb (Month) 26 (Day), 1920 (Year)

7-AGE, 1 yrs. 3 mos. 18 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Blake

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Flossie Storm

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Blake
(Address) 654 Josephine St.

15-
Filed Robert P. Harrison, Registrar.
9-1921 Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jun 6 1921, to Jun 8 1921, that I saw him alive on Jun 8 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) None
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. R. Kenyon M. D.
6/8/21 (Address) 609 W. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. | In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, June 10, 1921

20-UNDERTAKER Burns & Baldwin | ADDRESS 1140 W. Baltimore St.

Important. See instructions on back of Certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54397

D 54397

81

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2706 N Charles ST.: 17 WARD)

2-FULL NAME Anna M. Gunts

(a) RESIDENCE. NO. 2706 N Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S., if of foreign birth? 68 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26-1828

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) *General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Gunts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mckinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Wm Gunts 2306 N Charles st

15 Filed Robert P. Harrison, Registrar

JN 9—1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1919, to June 8th, 1921, that I last saw h.e.r. alive on June 6th, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Poor

Aortic Aneurism

Stated (duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Fox M. D.

6/9, 1921 (Address) 11 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	June 11 1921
20 UNDERTAKER H. E. Buckmaster Sons	ADDRESS North Ave

TION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Ft Four
12 6.25 at
Not luetic probably
due to senility.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

D 54398 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54398

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2126 E Oliver ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel May Bond

(a) RESIDENCE. NO. 2126 E Oliver ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16 20

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward E Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Helen Klepper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

11 Informant Edward E Bond
(Address) 2126 E Oliver St

15 Filed JUN 9-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 8, 1921, that I last saw h alive on June 8, 1921, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. C. Campbell M. D.

(Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cem June 10 1921

20 UNDERTAKER ADDRESS

Wm Cahsin E Balto

TION is very important. See instructions on back of certificates.

D 54399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 54399

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1337 N. Calhoun St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel Gasaway

(Residence in Baltimore: No. 1337 N. Calhoun St. St. 1 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6-DATE OF BIRTH, November, 1863
(Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Joe Kier

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Rachel Green

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Spencer Gasaway

(Address) 1337 N. Calhoun St.

15- FILED JUN 10 1921 191 [illegible] Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the date stated above.

The CAUSE OF DEATH* was as follows:

Cellular tuberculosis of lungs

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. E. T. Hennessy M. D.
(Attending)

June 9, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Star Cemetery

DATE OF BURIAL, 6/10/21 19

20-UNDERTAKER Catonsville Md

ADDRESS 903 Edmondson Ave Catonsville Md

Edward W. Sipe.

CAUSE OF DEATH. Please print plainly. Items are important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 646 D 54400 — X 108 D 54400 ✓

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Hunt

(a) RESIDENCE. NO. 1541 Orleans ST.. WARD. South Carolina

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Hunt

6 DATE OF BIRTH (month, day, and year) Oct 17-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina live in Baltimore 8 months

PARENTS

10 NAME OF FATHER Sam Haddon

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Lucie Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUN 10 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5 , 1921 , to June 8 , 1921 , that I last saw h[illegible] alive on June 8 , 1921 , and that death occurred, on the date stated above, at 1105 m.

The CAUSE OF DEATH* was as follows:

Shock resulting from General peritonitis following acute appendicitis (perforated)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 6/8/21

Was there an autopsy? Yes

What test confirmed diagnosis? Surgeons, pathologist and operation

(Signed) T. H. Hunter, M. D.

6-9-1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 12 1921
20 UNDERTAKER Wm R A Elliott	ADDRESS 1725 Ashland Ave

TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Bks.

Willie P. Bates

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54401

D 54401

CERTIFICATE OF DEATH.

REGISTERED NO. C 664

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Cathedral ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willie Pearce Bates

(Residence in Baltimore: No. 905 Cathedral St.; 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~. (Write the word.) Widow

6-DATE OF BIRTH, 12 (Month) 6 (Day), 1858 (Year)

7-AGE, 62 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Petersburg Va.

PARENTS.

10-NAME OF FATHER. George Francis Sears

11-BIRTHPLACE OF FATHER (State or Country), Petersburg Va.

12-MAIDEN NAME OF MOTHER Adaline M Harrod

13-BIRTHPLACE OF MOTHER (State or Country), Petersburg Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucie M. Kraus

(Address) 905 Cathedral St

15-

Filed JUN 10 1921 ROBERT J. KRAUTER Registrar

Burial cert. issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6 (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1921, to June 1921, that I saw her alive on June 9 1921, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(Duration) yrs. 2 mos. ds.

(Signed) C. Watson Smith M. D.

June 10, 1921. (Address) 817 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Charlotte N.C.

DATE OF BURIAL, 6/11/21., 191...

20-UNDERTAKER Geo J Smith

ADDRESS 1000 W Fayette St

Important. See instructions on back of certificate.

Not apoplectic. Thrombotic.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54402

CERTIFICATE OF DEATH.

159 D 54402

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 400 N Gilmor St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Bates

(Residence in Baltimore: No. 400 N Gilmor St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6-DATE OF BIRTH, unknown (Month) (Day), 1903 (Year)

7-AGE, 18 yrs. mos. ds.

If LESS than 1 day, hrs. or mtn.?

8-OCCUPATION: 637
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE. (State or Country): Balto. City

PARENTS.

10-NAME OF FATHER: Ernest Simpson

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or Country): Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. D. G. Mack

(Address) 2133 Druid Hill Ave

15- Filed JUN 10 1921 191 ROBERT A. KRAUTER, Registrar.

Burial 11 a.m.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Bullet wound through heart

Shot by self in left side

Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

June 10, 1921. (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Pikesville DATE OF BURIAL, June 10, 1921

20-UNDERTAKER, David Hemsley ADDRESS 758 N Bidde St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54403

CERTIFICATE OF DEATH.

37 D 54403

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1534 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora Thomas

(Residence in Baltimore: No. 1534 McCulloh St.: 13 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, June (Month) ..... (Day), 1883 (Year)

7-AGE, 38 yrs. — mon. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), N.C.

PARENTS.

10-NAME OF FATHER, Lewis John Lasiter

11-BIRTHPLACE OF FATHER (State or Country), N.C.

12-MAIDEN NAME OF MOTHER Caudis Baker

13-BIRTHPLACE OF MOTHER (State or Country), N.C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lasiter

(Address) 1534 McCulloh St

15-

Filed JUN 10 1924 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 9 (Day), 1924 (Year).

17- I HEREBY CERTIFY, That I attended deceased from May 20 1924, to June 9 1924, that I saw her alive on June 9 1924, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) Coma

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) W. F. Carr M. D.

June 10, 1924 (Address) 515 Fairbanks

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cofield Station Stanford Co. N.C.

DATE OF BURIAL, June 11, 1924

20-UNDERTAKER John H. Tradin

ADDRESS until 24

important. See instructions on back of certificate

Probably fluctic.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 54404

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1004 A. Eutaw ST. 71 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Cornish

(a) RESIDENCE. No. 1004 A. Eutaw ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/9/1898

7 AGE: Years 22 Months 9 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Henry Cornish

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Fannie Brooks 1004 A. Eutaw St.

15 Filed JUN 10 1921 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7/1921

17 I HEREBY CERTIFY, That I attended deceased from 6/5/1921, to 6/7/1921, that I last saw her alive on 6/4/1920, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Influenza non epidemic

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Crowley M. D.

6/7/1921 (Address) 938 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn DATE OF BURIAL: June 10 1921

20 UNDERTAKER: John H. Toadvine ADDRESS 142 Watts St

CAUSE OF DEATH must be stated by physician. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54405

CERTIFICATE OF DEATH.

X 109

D 54405

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene L. Harris

(a) RESIDENCE. NO Lanerview Va ST., WARD. Lanerview Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married Wife

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 45 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hodsworth

(b) General nature of Industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer [illegible]

9 BIRTHPLACE (city or town) (State or country) Middle ty Co. Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middle ty Co.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. J. Reed 706 Gold St.

15 Filed JUN 10 1921 ROBERT J. CRAIGHILL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4 1921, to June 9 1921, that I last saw h alive on June 9 1921, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction (operation) duration yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 706 Gold St.

Did an operation precede death? Yes Date of June 7-21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [illegible] M. D.

(Address) 1413 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Middle Neck Baltimore Co. DATE OF BURIAL June 10 1921

20 UNDERTAKER James H Daniels ADDRESS 130 Preston St

mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54406

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54406

CERTIFICATE OF DEATH

Hamilton 79 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 Hilsa Ave ST.; 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Johannah Brooning

(Residence in Baltimore: No. 107 Hilsa Ave St.; 70 yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, Dec 25th, 1839
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
81 yrs. 5 mos. 13 da.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Frederick Bauer

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Johannah Bauer

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Brooning

(Address) 107 Hilsa Ave

15- JUN 10 1921 191.... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7th, 1921.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from January 15 1921, to June 7th 1921, that I saw her alive on June 7th 1921, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease Heart

(Duration) Do not know yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) H. J. Carrick M. D.

June 8th, 1921. (Address) 412 N. Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	June 10, 1921
20-UNDERTAKER	ADDRESS
Jos Joerdens Son	217 S. Paca

Important. See instructions on back of certificate.

Watt

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54407

D 54407

CERTIFICATE OF DEATH.

REGISTERED NO. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. on way to Mercy Hospital WARD) 21

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Watt.

(Residence in Baltimore: No. 721 W. Hamburg, St.; 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 8 (Day), 1867 (Year).

7-AGE, 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Painter
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Richard Watt.

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Emma Brown.

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Watt

(Address) 721 Hamburgh

15- Filed JUN 10 1921 191 [illegible] Clerk. Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said (~~Inquest, au~~ ~~topsy~~ or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) 1 day

CONTRIBUTORY (Secondary) Alcoholism

(Duration) yrs. mos. ds.

(Signed) W. K. Gorsuch M. D. (Coroner.)

6-10, 1921 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western — DATE OF BURIAL, June 12, 1921

20-UNDERTAKER John J Gable — ADDRESS 1200 W Fayette

CAUSE OF DEATH must be plainly written. All questions should be answered if important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54408

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54408

63

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 N. Fulton Ave ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary P. Kraft

(a) RESIDENCE. NO. 1140 N. Fulton av WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of the late Chas. Kraft

6 DATE OF BIRTH (month, day, and year) Oct 10-50

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary P. Smith

(Address) 1140 N. Fulton av

15 FILED JUN 10 1921 BOARD OF HEALTH Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1921, to June 8, 1921, that I last saw her alive on June 7th, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

0 0321

Right Hemiplegia Paralysis

Senile Atrophy Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard C. Silver M. D.

. 19 (Address) 3706 Liberty Heights av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	June 10 1921
20 UNDERTAKER Philip Henrig	ADDRESS 2066 Adams

N. B.—[illegible] should be carefully supplied. AGE should be [illegible] mation should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Phy. does not think deceased
had terminal cerebral
hemorrhage. More of
progressive paralysis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54409

D 54409 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 91-100

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Linwood Hewitt

(a) RESIDENCE. NO. #117 W. Franklin St ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Clara A. Hewitt

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk, 009

(b) General nature of industry, business, or establishment in which employed (or employer) Has been retired

(c) Name of employer 2 Years

9 BIRTHPLACE (city or town) (State or country) Hordstown N. J.

PARENTS

10 NAME OF FATHER Thos. Hewitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Clara A Hewitt (Address) 117 W. Franklin St

15 Filed JUN 10 1921 [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1921, to June 8, 1921, that I last saw him alive on June 8, 1921, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (following Influenza & Acute diabetes)

(duration) 5 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of June 4 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Reyer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk	June 11 1921
20 UNDERTAKER Philip Herwig	ADDRESS 206 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54410

CERTIFICATE OF DEATH. X 91 · 079 D 54410

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth E. Chipman

(a) RESIDENCE. NO. Harrington, Delaware ST.. WARD. Harrington Del.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Dr Wm. T. Chipman

6 DATE OF BIRTH (month, day, and year) March 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER E. H. Berdine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Keithly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Wm T Chipman

(Address) Harrington Del

15 Filed JUN 10 1921 ROBERT I. BRUCE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1921

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1921, to June 9th, 1921, that I last saw her alive on June 9th, 1921, and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination.

(Signed) Geo. L. Wissig, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrington Del	June 10 '21
20 UNDERTAKER	ADDRESS
Henry H Jenkins Sons	Orchard & Caroline

FAILURE TO FILE IN PROPER TIME AND PROPERLY FILL OUT ALL ITEMS ON BACK OF CERTIFICATE. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Fleisher

D 54411

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

104-091 D 54411

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Fleisher

(Residence in Baltimore: No. 1633 E. Balto St St.; ___ yrs., 1 mos. ___ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 2 (Day), 1920 (Year)

7-AGE, ___ yrs. 1 mos. 7 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ___
(b) General nature of industry, business, or establishment in which employed (or employer) ___

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Morris Fleisher

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Freida Cohen

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15- Filed JUN 10 1921 191 ROBERT J. KRAUTER Registrar of Vital Statistics.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 4 1921, to June 9 1921, that I saw h— alive on June 9 1921, and that death occurred, on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows:

Infantile Diarrhoea

(Duration) ___ yrs. ___ mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) ___ yrs. ___ mos. 4 ds.

(Signed) I. Ginsberg M. D.

June 9, 1921 (Address) Atlantic Hotel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ___ yrs. ___ mos. 5 ds. In the State ___ yrs. 1 mos. 17 ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 1633 E Balto St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, June 11, 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

important. See instructions on back of certificate.

Ozakewski

D 54412

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54412

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Hopkins Hospl St. 1 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Ozakewski.

(Residence in Baltimore: No. 612 S Decker ave 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Married

6-DATE OF BIRTH, April (Month) 16 (Day), 1893 (Year)

7-AGE, 29 yrs. 1 mos. 27 ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tester 086
(b) General nature of industry, business, or establishment in which employed (or employer)..... Vinegar Plant

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Ozakewski

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbara Odrowski

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lucy Ozakewski
(Address) 612 S Decker Ave.

15- FILED JUN 10 1921, 191. Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:—
(a) Acute Heart Disease
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. W. Faulkner M. D.
(Coroner)
, 191... (Address) Coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary. DATE OF BURIAL, June 11, 1921.

20-UNDERTAKER William Fiedkowski ADDRESS 1141 Eastern Ave

N.B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause important. See instructions on back of certificate.

D 54413

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3E. Montgomery ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Virginia Tall

(a) RESIDENCE. NO. 3E. Montgomery ST., WARD. 22

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 4 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced WIFE of Reuben Henry Tall Sr

6 DATE OF BIRTH (month, day, and year) Jan 11 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph N. Horner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Hannah E Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Reuben H. Tall (Address) 3E Montgomery

15 JUN 10 1921 ROBERT J. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1 1921 to June 9 1921, that I last saw her alive on June 9 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE (IF DEATH)* was as follows:

Infirmities of age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F. Edw Linard M. D.

1921 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	JUN 13 1921

20 UNDERTAKER JOHN F. DENNY ADDRESS 716 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 54414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

640 D 54414

REGISTERED NO. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. 10 E Virginia ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie E Foerster

(Residence in Baltimore: No. 10 E Virginia

57 yrs., 6 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov. 19, 1863
(Month) (Day) (Year)

7-AGE, 57 yrs. 6 mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. H. W. 37
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). City

PARENTS.

10-NAME OF FATHER. Jno C Foerster

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Louthon

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E Foerster

(Address) 10 E Virginia ave

15-

JUN 10 1921, 191 ROBERT J KRAUTER Registrar.

Burial Permit Issued

CAUSE OF DEATH to be filled in plainly and important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Duration) yrs. 1 mos. 1 hr.

CONTRIBUTORY (Secondary) Chronic Cystitis

(Duration) yrs. mos. da.

(Signed) G. C. Gladstone M. D.
(Coroner)

6/9/21, 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Int Olivet Cem DATE OF BURIAL, June 191 21

20-UNDERTAKER J A Moran ADDRESS 320 E Balto St.

Spec—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54415

CERTIFICATE OF DEATH.

151 D 54415

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3650 Elm Ave. St.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Roth Jr.

(a) RESIDENCE No. 3650 Elm Ave. St. 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs — mos 6 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 3-1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Roth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Bessie E. Handy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md.

14 Informant Louis Roth
(Address) 3650 Elm Ave

15 Filed . 19 JUN 10 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3 . 1921 . to June 9 . 1921 .

that I last saw h~~im~~ alive on June 9 1921.

and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Syncope (Blue baby) 8 ct
Month Gestation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical manifestations

(Signed) L. R. Wantz M. D.

June 10 1921 (Address) 865 N. 30th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	June 10 1921

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Falls Rd.

CAUSE OF DEATH to be plainly written. Any unusual condition contributing to death should be stated. Every question must be answered, or certificate will be returned. TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54416

CERTIFICATE OF DEATH.

79 D 54416

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 142 Druid Hill Ave. St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christopher C. Kent.

(Residence in Baltimore: No. 1421 Druid Hill Ave. 55 yrs. — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, April 27, 1866 (Month) (Day) (Year)

7-AGE, 55 yrs. 1 mos. 14 da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dr.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Agent

9-BIRTHPLACE, (State or Country), West Va

PARENTS.

10-NAME OF FATHER, John Kent

11-BIRTHPLACE OF FATHER (State or Country), West Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Kent

(Address) 1421 Druid Hill Ave

15- JUN 10 1921 Filed..... 191... ROBERT I. RANEY Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12 1921, to June 9 1921, that I saw h.. alive on June 9 1921, and that death occurred, on the date stated above, at 5:30a m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Dilatation

(Duration) ....yrs. 1 mos. ....da.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) ....yrs. ....mos. ....da.

(Signed) W. J. Carrington M. D.

June 10, 1921. (Address) 15 W. Mount

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, June 12 1921

20-UNDERTAKER George H. Holland ADDRESS 1631 N. Mid Ave

Cross out what is not important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

148614

D 54417

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54417

150

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.) (3) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sift

(a) RESIDENCE. NO. 220 S Caroline ST St., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1/6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Isadore Sift

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Cark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUN 10 1921 BOWEN & KRAUTER Registrar

Burial ... Permit ...

CAUSE OF DEATH in plain terms, so that it may be understood. Name of disease alone is not sufficient. Indefinite terms, such as "Heart Disease," "Cancer," "Tumor," "Kidney Trouble," "Blood Poisoning," "Pneumonia," "Fever," "Debility," "Old Age," "Accident," "Fracture," "Drowning," are not sufficient. Deaths from violence must state the means. Deaths from accident must state whether it was accidental, suicidal or homicidal. Deaths during childbirth must state the influence of childbirth. Deaths from any cause during the first year of life must state the number of months and days of age. Deaths from any cause under five years of age must state the number of years, months and days of age. Deaths from any cause over five years of age must state the number of years of age. Physicians are requested to fill out this certificate in accordance with these instructions. Carefully read the certificate on the back of certificates. See instructions on back of certificates. This information is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3 1921 to June 10 1921

that I last saw h alive on June 10 1921

and that death occurred, on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Meningocele

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Hydrocephalus

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) W. D. Davison M. D.

(6-10, 19 21) (Address) 1111 Bolt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	June 1921
20 UNDERTAKER	ADDRESS
Kevenor	E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54418

D 54418

113

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 N. Central Ave ST. 10 WARD)

2-FULL NAME Louis L. Cohen

(a) RESIDENCE. NO. 727 N. Central Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mat Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Fanny Cohen
(Address) 727 N Central Ave

15 Filed JUN 1 0 1921 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from April 6 1921 to June 9 1921.

that I last saw h alive on June 9 1921.

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx
(Inoculation of Sputum in Guinea Pig)

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Probably

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Examination

(Signed) Osmond, M. D.

19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	June 10 1921
20 UNDERTAKER Mary Lovington	ADDRESS 1127 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54419

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54419

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 917 Elm Place St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Pinckney

(Residence in Baltimore: No. 917 Elm Place St.: 1 yrs. 2 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March (Month) 27 (Day), 1920 (Year)

7-AGE, 1 yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Howard Pinckney

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Jennie Caldwell

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Pinckney

(Address) 917 Elm Place

15-

Filed JUN 10 1921 ROBERT I. BLAKE Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 7 1921, to June 9 1921, that I saw her alive on June 9 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(Duration) 1 yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. L. Joslin M. D.

June 10, 1921. (Address) 33 W. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, June 13, 1921

20-UNDERTAKER David Taylor

ADDRESS 916 Ca...

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54420

CERTIFICATE OF DEATH.

8-091 D 54420

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1054 William ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D. Gemmershausen

(a) RESIDENCE NO. 1054 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Wht

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 22 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Philip Gemmershausen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary McNeil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Philip Gemmershauser

(Address) 1057 Williams St

15 JUN 10 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1921, to June 10, 1921,

that I last saw her alive on June 10, 1921,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

2 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Schimmel, M. D.

(Address) 3101 Gerson Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A.A.Co.	6-11 1921
20 UNDERTAKER	ADDRESS
E. & B. Hartz 115	E. Madison

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54421

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54421

CERTIFICATE OF DEATH.

119

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2412 Edmondson ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Friedrichs

(a) RESIDENCE. NO. 2412 Edmondson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 10 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry F. Friedrichs

6 DATE OF BIRTH (month, day, and year) July 24 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Adam Peter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Conrad

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary Friedrichs
(Address) 2412 Edmondson ave

15 Filed ... Robert P. Harrison, Registrar
Burial Permit Clerk

N 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4th, 1921, to June 10th, 1921, that I last saw h.. alive on June 9th, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Diagnosis signs

(Signed) Chas Geltz M. D.

(Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 13th 1921
20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2563 Edmondson ave

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition than age.

D 54422

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 54422

CERTIFICATE OF DEATH

REGISTERED NO. C 120

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 200 E. Oakdale Rd - Rld. Park ST.: 29 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mrs. Wm C. McMullen

(Residence in Baltimore: No. 200 E. Oakdale Rd. Roland Pk St.: 6 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feb (Month) 2nd (Day), 1847 (Year)

7 AGE: 74 yrs. 4 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Wife retired Dairy Business
(b) General nature of industry, business, or establishment in which employed (or employer): (Self) 045

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm McMullen

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret J. Crawley

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm J. Wm. McMullen

(Address) 1 DeSoto Apts Balto City

15 Robert P. Harrison,

Filed JUN 10 1921, 191 Burial Permit Clerk REGISTRAR

N. B.—Every item of information called for by this certificate should be carefully considered, and the answer written in such terms as properly classified. Exact statement of OCCUPATION, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 9th (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18th, 1915, to June 9th 1921,

that I saw him alive on June 8th, 1921,

and that death occurred, on the date stated above, at 10 45 A m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(Duration) ? yrs. mos. ds.

Contributory (SECONDARY) Arterio-sclerosis - Chr. Nephritis - Senility

(Duration) ? yrs. mos. ds.

(Signed) Fdenham R. Clarke M. D.

June, 1921 (Address) Roland Park Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			
Where was disease contracted, if not at place of death?							
Former or usual residence							

19 PLACE OF BURIAL OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: June 11, 1921.

20 UNDERTAKER: S. LEVERT & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54423

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54423

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 So. Curley ST.: 1. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ANNA U. BRILL,

(a) RESIDENCE. NO. 722 So. Curley ST., I. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Single,

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 7-1920,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child,

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER Talbot W. Brill,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, MD.

12 MAIDEN NAME OF MOTHER Mary Zywicka,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carptner, PA.

14 Informant Talbot W. BRILL,
(Address) 722 So. Curley Street

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk

N 101921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9- 1921.

17 I HEREBY CERTIFY, That I attended deceased from June 6 . 1921 . to June 9- . 1921 .

that I last saw her alive on June 9- . 1921 .

and that death occurred, on the date stated above, at 8.30 P- m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis -

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Convulsions -

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Foster Brooks, M. D

June 10 1921 (Address) 125 S Bond -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	June 11" 1921.
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	705 S. Ann

CAUSE OF DEATH to be given in plain English. Do not use abbreviations or technical terms. See instructions on back of certificates.
TION is very important.

Spec. 6-9-19 H. P. Co. 1000 Bks.

14865 D 54424

HEALTH DEPARTMENT—CITY OF BALTIMORE D 54424

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Manlolin

(a) RESIDENCE. NO. Spencer, R. 6 ST.. WARD. Spencer N. C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15-1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Wm H Manlolin

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Sarah Beaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant (Address) Johns Hopkins Hospital Robert F. Harrison, Reach

15 1921 . 19 Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6 . 1921, to June 9 . 1921.

that I last saw h alive on June 9 . 1921.

and that death occurred, on the date stated above, at 6 15 a m.

The CAUSE OF DEATH* was as follows:

Brain tumor - (cerebellar?) with marked pressure symptoms

(symptoms) (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? Yes Data of June 7, 21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harvey Cushing, M. D.

6-9-1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Salisbury N. C. June 10 1921

20 UNDERTAKER ADDRESS

John Mitchell 120 W. Fayette St.

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

D 54425

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-079

D 54425

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 6 Warner or Hullsville ST. 25 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Daniel Thomas

(Residence in Baltimore: No. 6 Warner st Hullsville St. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
M	Colld.	Married

6 DATE OF BIRTH April 12, 1873 (Month) (Day) (Year)

7 AGE 48 yrs. mos. ds. If LESS than 1 day, ... hrs. or .... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Thomas

11 BIRTHPLACE OF FATHER (State or country) ~~Md~~ Va

12 MAIDEN NAME OF MOTHER Mary Scott

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Irmgard A Thomas

(Address) Hullsville

15 [illegible] Robert E. Harrison, [illegible] 191 [illegible] Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 (Month) 9 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 6-4-, 1921, to 6-8, 1921, that I saw h[illegible] alive on 6-8-, 1921, and that death occurred, on the date stated above, at 7 a. m.
The CAUSE OF DEATH* was as follows:

Influenza
congestion of Lungs

(Duration) .... yrs. .... mos. 9 ds

Contributory (SECONDARY) Cardiac insufficiency

(Duration) .... yrs. .... mos. 4 ds.

(Signed) [illegible] M. D.

6-10, 1921 (Address) Hullsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.
Where was disease contracted, if not at place of death?
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Mt Auburn

DATE OF BURIAL June 12, 1921

20 UNDERTAKER Edw Ringgold

ADDRESS 1068 Cross St

N.B.-Every item of information should be entered, supplied, if it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54426

D 54426

CERTIFICATE OF DEATH.

42

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 E. Lafayette Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen K Hayd

(Residence in Baltimore: No. 1735 E. Lafayette Ave. St.; Nurse yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, October (Month) 9th (Day), 1855 (Year)

7-AGE 66 yrs. 7 mos. 30 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Balto. Md

PARENTS.

10-NAME OF FATHER, Joseph Kennard

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md,

12-MAIDEN NAME OF MOTHER Sarah

13-BIRTHPLACE OF MOTHER (State or Country) Eastern Shore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C H Hayden Jr

(Address) 1735 E. Lafayette Ave

15-

Filed ..... 191..... Registrar.

Robert P. Harrison,

N 1 01921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 8 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 20 1921, to June 8 1921, that I saw h e alive on June 6 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

a Carcinoma Uterus

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Jacob Frahm M. D.

June 10, 1921. (Address) 1823 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem. DATE OF BURIAL, June 11, 1921

20-UNDERTAKER George J Ruth ADDRESS 1735 Hanfordtown

Cross out words not important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54427 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54427

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Belt St. ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian A. White

(a) RESIDENCE. No. 1416 Belt St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs 6 mos 4 ds How long in U. S., if of foreign birth? 1 yrs 6 mos 4 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George B. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Margaret Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. White (Address) 1416 Belt St.

15 Filed NOV 1 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7. 1921, to June 10, 1921, that I last saw h[illegible] alive on June 10, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. P. Campbell, M. D.

, 19 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	6/13 1921
20 UNDERTAKER	ADDRESS
J. Fenwick Cully.	130 E Fort

CAUSE OF DEATH in plain terms, so that it may be understood by persons in general. Do not use abbreviations or technical terms. Carefully read the questions on back of certificates. TION is very important. See instructions on back.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 54428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54428

CERTIFICATE OF DEATH.

119

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 154 N. Linnwood Ave. ST.: 6 WARD)

2-FULL NAME Mary E. Fowler

(a) RESIDENCE. No. 154 N. Linnwood Ane. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs 11 mos 7 ds. How long in U. S., if of foreign birth? 36 yrs 11 mos 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel G. Fowler

6 DATE OF BIRTH (month, day, and year) July 3 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	36	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James E. Newkirk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Sarah E. Heissen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) James Newkirk 154 N. Linnwood

15 Filed . 19 Robert F. Harrison, Registrar

JUN 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 June 1921

17 Dr Imaly attended case Brain

I HEREBY CERTIFY, That I attended deceased from May 25 . 1921 . to 10 June . 1921.

that I last saw him alive on 9 June . 1921.

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows: 0737

Cerebral Hemorrhage

(duration) yrs. mns. ds.

CONTRIBUTORY (Secondary) (duration) yrs 2 mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Appearance of brain at autopsy

(Signed) Dr Smith . M. D.

. 19 (Address) 3018 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: 6/13 1921

20 UNDERTAKER: J. Fus McCully — ADDRESS: 130 E Fort

CAUSE OF DEATH to plain terms. So that it may be TION is very important. See instructions on back of c

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history of any other abnormal condition.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54429

64

D 54429

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1361 W. North Ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number,)

2-FULL NAME Charles Edward Zellers

(a) RESIDENCE. NO. 1361 W N. Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Zellers

6 DATE OF BIRTH (month, day, and year) Dec 7 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John F. Zellers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sonntag

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E Zellers (Address) 1361 W N. Ave

15 Filed JUN 11 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3rd 1921. to June 10. 1921.

that I last saw him alive on June 9 1921.

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas St. J. Gilbert, M. D.

June 10 1921 (Address) 1100 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md	June 10 1921

20 UNDERTAKER Upton Corbin. ADDRESS 1024 E Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified, is very important. See instructions on back of certificates.

UN 11 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54430 HEALTH DEPARTMENT—CITY OF BALTIMORE 120 D 54430

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 Oak — ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millard - H. Gambrill..

(a) RESIDENCE NO. 2118 Oak St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs 3 mos ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia F. Gambrill.

6 DATE OF BIRTH (month, day, and year) May 7-1857.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant 209

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Merchants & Miners Co

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry W. Gambrill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary C McCaslin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Julia F. Gambrill. (Address) 2118 Oak St

15 [illegible] Robert P. Harrison, Registrar

Burial Permit Clerk.

N 11 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 9 1921 to June 10 1921.

that I last saw h[illegible] alive on June 9 1921.

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo M Stitt M. D.

6/10 1921 (Address) 2430 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Greenmount June 12 1921

20 UNDERTAKER — ADDRESS

Wm Cook & Son 502 E. Hatton

CAUSE OF DEATH to be given in plain English. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54431

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 North Payson St.; 16 Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina Hellinger

(Residence in Baltimore: No. 928 North Payson St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, August 3rd (Month) (Day), 1847. (Year)

7-AGE, 73 yrs. 10 mos. 5 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, George Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Christina Schmidt

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Veda Hellinger

(Address) 928 N. Payson St

15-

JUN 11 1921

Robert P. Harrison,
Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8th (Month) (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 28th 1921, to June 8th 1921, that I saw h.. alive on June 8th 1921, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

..... (Duration) — yrs. — mos. 6 ds.

(Signed) Elgar D. Perkins M. D.

June 8th, 1921. (Address) 1 W Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	June 11, 1921.
20-UNDERTAKER	**ADDRESS**
Geo Limbach & Sons	640 W Pratt

IMPORTANT. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54432 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54432

CERTIFICATE OF DEATH. 130

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie Leach

(a) RESIDENCE. No. 629 W 33rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb 24 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) HOW

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Charles Leach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Bronner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

11 Informant Mr. Leach

(Address) 629 W. 33rd St

15 Filed ..... 19 Robert P. Harrison Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/10/1921

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1921, to June 10, 1921, that I last saw h[illegible] alive on June 10, 1921, and that death occurred, on the date stated above, at 11. 6 m.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probable Uremia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of June 9/21

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & Symptoms

(Signed) Eugene Heyward, M. D.

19 (Address) 23 - W. Franklin.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL June 13 21

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Gaud Rd

CAUSE OF DEATH. Be sure to give cause in each line. See instructions on back of certificates. TION is very important.

JUN 15 1921

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54433

D 54433

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rodgers Ave ST.; Over Hill Top Road WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruben B. Whitaker

(Residence in Baltimore: No. Rodgers Ave St.; 0 yrs., 1 mos. 17 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, Feby 24, 1841. (Month) (Day) (Year)

7-AGE, 80 yrs. 3 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: farmer retired
(b) General nature of industry, business, or establishment in which employed (or employer): ---

9-BIRTHPLACE, (State or Country). Ohio

PARENTS.

10-NAME OF FATHER, Ruben B. Whitaker

11-BIRTHPLACE OF FATHER (State or Country). New Jersey

12-MAIDEN NAME OF MOTHER Fannie Horton

13-BIRTHPLACE OF MOTHER (State or Country). Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jennie Whitaker

(Address) 0 Downing Rd Cat.

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 10, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 8 1921, to June 10 1921, that I saw h him alive on June 9 1921, and that death occurred, on the date stated above, at 10.15 Am m.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Diseased Heart

(Duration) 4 yrs. 2 mos. ds.

(Signed) William J. Todd M. D.

June 11, 1921. (Address) 711 Washington Blvd Baltimore Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Denver Col.

19-PLACE OF BURIAL OR REMOVAL, Denver Colorado DATE OF BURIAL, June 12, 191...

20-UNDERTAKER, A. S. Marshall ADDRESS 36-39 Edmondson Ave

IN 11921

Do not write in this space. See instructions on back of certificate. important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 54434 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54434

CERTIFICATE OF DEATH. 104-091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (ST.) 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel Geis

(a) RESIDENCE. NO. 629 E. 20th St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Mabel Geis (Mother)

6 DATE OF BIRTH (month, day, and year) Oct 26 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Elmer C. Geis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mabel Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital Record

15 Filed . 19 Robert F. Harrison, Registrar

N 1 1921 Burial Permit Clerk

CAUSE OF DEATH in plain terms, and TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10 . 1921 . to June 10 . 1921 . that I last saw her alive on June 10 . 1921 . and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) W C Davison . M. D.

6-11, 1921 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL June 13 1921

20 UNDERTAKER for Joerdens Son ADDRESS 2173 Pa

Spec.—6-0-19—H. P. Co.—1000 Bks.

D 54435

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54435

CERTIFICATE OF DEATH.

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 W Mulberry ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Walker

(a) RESIDENCE. NO. 724 W Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Wd.

5a ~~If married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Henry Walker

6 DATE OF BIRTH (month, day, and year) June 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Anson Co N C

PARENTS

10 NAME OF FATHER Richmond Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Viletta Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Mary Black

(Address) 724 W Mulberry St

15 Filed JUL 1 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1921, to June 12th, 1921, that I last saw h[illegible] alive on June 12, 1921, and that death occurred, on the date stated above, at 12:10 a m.

The CAUSE OF DEATH* was as follows: OVER

Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no —

What test confirmed diagnosis? —

(Signed) W Garrison Marks, M. D.

6-16 1921 (Address) 701 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 12 1921
20 UNDERTAKER	ADDRESS 114 N.
Brown & Buckland	Schroeder St.

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. See instructions on back of certificates. TION is very important.

30 Colored

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not luetic. Arteria Sclerosis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54436

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54436

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Homewood Apts. Charles 31st ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bianca M. Hilgartner

(a) RESIDENCE. NO. Homewood Apts. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L Hilgartner

6 DATE OF BIRTH (month, day, and year) Nov. 26th 1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stephen Schroedl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Munich Germany

12 MAIDEN NAME OF MOTHER Anna Muhlhann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Leipsig Germany

14 Informant Andrew H. Hilgartner

(Address) Homewood Apts.

15 Filed JUN 11 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from September, 1920, to June 9th, 1921, that I last saw her alive on June 9, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

General Arterio-Sclerosis

Chronic Interstitial nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Synopsis

(Signed) A. D. Aikman, M. D

6/10, 1921 (Address) 1010 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	June 13 1921
20 UNDERTAKER	ADDRESS
J. & B. Cook	1002 N. Balto

CAUSE OF DEATH in plain terms. Indefinite answers, such as "old age," "debility," "cancer," "consumption," "dropsy," "fever," "heart disease," "kidney disease," "pneumonia," "tuberculosis," "typhoid fever," "uremia," "whooping cough," are not sufficient. Name the disease causing this condition, if any, or other important morbid conditions. Do not use abbreviations or initials. Do not report mere symptoms of death, such as "heart failure," "asthenia," "anemia," "uremia," "convulsions," "coma," "shock," "hemorrhage," "gangrene," "paralysis," "exhaustion," "cardiac arrest," "respiratory arrest," "pulmonary edema," "cerebral edema," "circulatory collapse," "septicemia," "pyemia," "blood poisoning," "multiple organ failure," "multiple system failure," "multiple organ dysfunction," "multiple system dysfunction

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 54437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54437

64

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Poplar ave. North Rear ST. 17 WARD)

2-FULL NAME Helena Mc Manus Goldsborough

(a) RESIDENCE. No. 3029 St Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~
~~HUSBAND~~ (or) WIFE of Harry P. Goldsborough

6 DATE OF BIRTH (month, day and year) 5-3-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	1	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lady ooo
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Dr Felix Mc Manus
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md
12 MAIDEN NAME OF MOTHER Julia Shultz
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Felix V. Goldsborough
(Address) 3029 St Paul St

15 Filed JUN 11 1921 19 Robert P. Harrison, Registrar
Asst Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept, 19 19, to June 9, 19 21,
that I last saw h~~e~~r alive on June 9, 19 21,
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Myocarditis
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Usual Examination
(Signed) Jerry M Smith, M. D.
6/11, 1921 (Address) 1430 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: 6-13 1921

20 UNDERTAKER: H W Jenkins & Sons Co — ADDRESS: McCulloh Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Neglect of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

See affadavit over

D 54438

HEALTH DEPARTMENT CITY OF BALTIMORE

D 54438

CERTIFICATE OF DEATH.

51

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Stockton ST. 15 WARD)

2-FULL NAME Mary ~~Hatton~~ Watts

(a) RESIDENCE NO. 1310 Stockton ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~ Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Dec. 12, 1920

7 AGE Years Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Walter E. Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Ella Sterling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Walter E. Watts

(Address) 1310 Stockton St.

15 Filed JUN 12 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1921, to June 10, 1921.

that I last saw ~~him~~ Her alive on June 10, 1921.

and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

, 19 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL June 12, 21

20 UNDERTAKER James H. Dennis ADDRESS 1305 Preston

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Baltimore, Md., June 24, 1921.

I do hereby make that the following changes should be made on Baltimore City Health Department's Death Certificate #D-54438.

The name of the deceased should be recorded as Mary E. Watts, instead of Walter Watts. The sex as female, instead of male, and the sentence reading "that I last saw him alive"etc should be "that I last saw her alive", etc.

E. William Frey
Physician.

Subscribed and sworn to before me this 24th day of June, 1921.

Reed Gaither
Notary Public.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54439

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54439

CERTIFICATE OF DEATH.

X 91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1104 N. Caroline St ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Randolph

(Residence in Baltimore: No. 1104 N Caroline St St.; yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, April (Month) 6 (Day), 1920 (Year)

7-AGE, 1 yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Decker Randolph

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Rosie Brown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Decker Randolph

(Address) 1104 N. Caroline St.

15-

Filed JUN 12 1921, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

CAUSE OF DEATH must be plainly stated. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 10 1921, that I saw h... alive on June 9 1921, and that death occurred, on the date stated above, at 8 00 m.

The CAUSE OF DEATH* was as follows: NW

Bronchial Pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Richard L Eichhorn M. D.

June 11, 1921 (Address) 1514 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Kingswood Va

19-PLACE OF BURIAL OR REMOVAL, Laurel cemetery. DATE OF BURIAL, June 12, 1921

20-UNDERTAKER E Bryan ADDRESS 403 N Arlington Ave

No infection prior

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54440

D 54440

CERTIFICATE OF DEATH.

4 120

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 Ivy alley ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Smith

(Residence in Baltimore: No. 209 Ivy Alley St.; 75 yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, — (Month) — (Day) 1865 (Year)

7-AGE, 56 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Gene Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

9-BIRTHPLACE, (State or Country). St Mary's Co Md

PARENTS.

10-NAME OF FATHER, William Fowler

11-BIRTHPLACE OF FATHER (State or Country) St Mary's Co Md

12-MAIDEN NAME OF MOTHER Harriet Barnes

13-BIRTHPLACE OF MOTHER (State or Country) St Mary's Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Downes

(Address) 925 Mc Donough St

15-

Filed....., 191.....

Registrar.

UN 1 5 102 Permit Clerk.

CAUSE OF DEATH is plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9th, 1921. (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 7th 1921, to June 9 1921, that I saw her alive on June 8th 1921., and that death occurred, on the date stated above, at 7.15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (Duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Duration) — yrs. — mos. 4 ds.

(Signed) Edward Cullackmore M. D.

June 10, 1921. (Address) 1202 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Laurel Cemetery	June 14, 1921
20-UNDERTAKER E Bryan	ADDRESS 402 Bond St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54441

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54441

CERTIFICATE OF DEATH.

45

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 Augusta Ave. Irvington ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eduard Frederick Gauss.

(a) RESIDENCE. NO. 2303 E. Oliver ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk Bank

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER H. F. Gauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER E. K. Stingle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Anna A. Gauss 24 Augusta Ave

15 Filed Robert F. Harrison, Registrar

Burial Permit Clerk.

JUN 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 3rd, 1921, to June 4th, 1921, that I last saw h/m alive on June 4th, 1921, and that death occurred, on the date stated above, at 10-15 P. m.

The CAUSE OF DEATH* was as follows:

Malignant Tumor of Lung.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis Hamman, M. D.

, 19 (Address) 1107 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	June 13 1921
20 UNDERTAKER	ADDRESS
Josiah Lyser	1606 N. Howard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54442 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54442

CERTIFICATE OF DEATH. X 43

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2913 Carlisle Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Marie Barry

(a) RESIDENCE. NO. 2913 Carlisle ST., WARD. Greenfield Mass

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greenfield Mass

PARENTS

10 NAME OF FATHER Daniel Barry

11 BIRTHPLACE OF FATHER (city or town) Enniskerine (State or country) Bradford County - Ireland

12 MAIDEN NAME OF MOTHER Jane Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) County Clare Ireland (State or country)

14 Informant Louise M. S. Jenkins (Address) 2913 Carlisle Ave. Balto.

15 Filed JUN 11 1921 Robert P. Harrison, Registrar

Muriel Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-15, 1921, to 6-10, 1921, that I last saw h alive on 6-8, 1921, and that death occurred, on the date stated above, at 5.45 a m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Cachexia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastatic Carcinoma of Pubis etc (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carlos L Fahnestock, M. D.

6/10, 1921 (Address) 2806 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenfield. Mass	June 11 1921
20 UNDERTAKER Wm. J Eckert Sons	ADDRESS W Va

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54443 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54443

40

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2110 Gough ST. 1 WARD)

2-FULL NAME Helen Kokoszka

(a) RESIDENCE. NO. 2110 Gough ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Kokoszka

6 DATE OF BIRTH (month, day, and year) June 10 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michael Wilk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant George Kokoszka (Address) 2110 Gough St

15 Filed Robert P. Harrison, Registrar

JUN 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1 1921, to June 10 1921, that I last saw h[illegible] alive on June 10 1921 and that death occurred, on the date stated above, at 8.50 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

5 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Grumelt M. D.

(Address) 1801 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	June 13 1921

20 UNDERTAKER John Matteber ADDRESS 1803 Bank St

mation should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPA-
may be properly classified. Exact statement of
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back
back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54444 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54444

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Matthews

(a) RESIDENCE. NO. 830½ Franklin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 870

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard county Md.

PARENTS

10 NAME OF FATHER Herman Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Catonsville Md.

12 MAIDEN NAME OF MOTHER Sadie Keeley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant New City Hosp. Records (Address)

15 Filed Robert P. Harrison, Registrar

JUN 11 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8 1921

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1921, to June 8, 1921, that I last saw her alive on June 8, 1921, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Media-stenal abscess. (probably T.B. in origin).

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute myocardial failure (prob. from pressure). (duration) ... yrs. ... mos. 15 Min.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. A. Holden M. D.

6/10 1921 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Howard Co Md	June 12 1921
20 UNDERTAKER	ADDRESS 916 Eutaw
David Easton	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact spelling must be given. TION is very important. See instructions on back of certificates.

D 54445

Spec.—6-9-20—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54445

14866 54445

54445

CERTIFICATE OF DEATH.

X 115

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James P Sneddon

(a) RESIDENCE. NO. Bayonne N.J. ST., WARD. Bayonne NJ.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James P Sneddon

6 DATE OF BIRTH (month, day, and year) July 7 1863 Christmas

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mech. Eng. 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER James Sneddon Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) Scotland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUN 12 1921 ROBERT [illegible] Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6 1921, to June 11 1921, that I last saw him alive on June 11 1921, and that death occurred, on the date stated above, at 2 15 D m.

The CAUSE OF DEATH* was as follows:

General Peritonitis (Pyogenic)

0082

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 7, 1921

Was there an autopsy? No

What test confirmed diagnosis? Phys. Examination

(Signed) H. S. Carter, M. D.

6/11, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bayonne N. J.	June 11 1921
20 UNDERTAKER	ADDRESS
John A Mitchell	1201 N. Fayette

INFORMATION SHOULD BE CAREFULLY SUPPLIED. Every item may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54446

CERTIFICATE OF DEATH.

79 D 54446

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No New City Hospital, Bay View St.) (3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Orliss

(a) RESIDENCE. No. 24 Albermarle St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed JUN 12 1921 ROBERT J. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921 to June 11, 1921

that I last saw him alive on June 10, 1921

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.
Myocardial insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) V B Sherman, M. D.

6/11/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 13 1921

20 UNDERTAKER ADDRESS

John [illegible] 426 S. Pac[illegible]

MARRIAGE should be entered on certificate. Exact statement of OCCUPATION may be properly classified. EXACT statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54447

CERTIFICATE OF DEATH.

19 D 54447

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 Clifford St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Stewart

(a) RESIDENCE. No. 833 Clifford St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Stewart

6 DATE OF BIRTH (month, day, and year) June 1-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co Md

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Samuel E. Stewart

(Address) 833 Clifford St

15 Filed JUN 12 1921 ROBERT I. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9. 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5 1921 to June 9 1921, that I last saw him alive on June 9 1921, and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis (duration) — yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis. (duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) F. C. Luikie, M. D.

Jan 10 1921 (Address) 313 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: June 12 21

20 UNDERTAKER: Chas. H. Johnson — ADDRESS: 446 N. Carrollton

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54448

CERTIFICATE OF DEATH.

79

D 54448

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Wall.

(a) RESIDENCE NO. Steuart & Valley St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Wall.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	Abt 75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Edward Cotter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary McSwaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Florence

(Address)

15 Filed JUN 12 1921 ROBERT J. BRUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 '21

17 I HEREBY CERTIFY, That I attended deceased from No record, 19.., to ....., 19.., that I last saw h.. alive on June 5 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of foot

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

June 11, 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — DATE OF BURIAL: June 13 1921

20 UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Greenmount Av.

mation should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Marie O'Neal

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

54449 — 151 — D 54449

REGISTERED No. C .....

54449

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 238 Eutaw St. Mt Winans ST.: 25 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mosie O'Neal

(Residence in Baltimore: No. 238 Eutaw St Mt Winans St.: 5yrs mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If so, write the word)
F	Colrd	X

6 DATE OF BIRTH 5 (Month) 11 (Day), 1921 (Year)

7 AGE ..... yrs. 1 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none 000
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER George O'Neal

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Ida Millingham

13 BIRTHPLACE OF MOTHER (State or country) S. C

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo O'Neal

(Address) 238 Mt Winans

15 JUN 12 1921 ROBERT I KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 (Month) 11 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-10-21, 191 , to June 10 1921 that I saw h er alive on 6-10 , 1921. and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cirrhosis

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

6-11-, 1921. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 6/12, 1921

20 UNDERTAKER Mrs Dent Horser

ADDRESS 606 W Lanvale St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54450

CERTIFICATE OF DEATH.

91-089

D 54450

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1827 N. Chapel ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Roberts

(a) RESIDENCE. No. 1827 N. Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 18 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Andrew J. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Edith M Pressinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Mr. Andrew J. Roberts
(Address) 1827 N. Chapel St

15 Filed JUN 12 1921 . 19 ROBERT I. GRIFFITH Registrar Social Service Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to June 15, 1921, that I last saw h[illegible] alive on June 11, 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Fracture

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Harry A. Bulwinkle, M. D.

, 19 2, (Address) 1612 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 18 1921
20 UNDERTAKER	ADDRESS
Henry Storck Son	1301 E Fayette St

MARBLE AND GRANITE WORKERS, ATTENTION! CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

8.091 D 54451

CERTIFICATE OF DEATH.

D 54451

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1733 Light ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Virginia Turner

(a) RESIDENCE. NO. 1733 Light ST.. WARD..

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 23. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Chas T. Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Virginia Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Chas T. Turner

(Address) 1733 Light St.

15 Filed JUN 12 1921 ROBERT J. BRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15 . 1921 . to June 12 1921.

that I last saw alive on June 11 . 1921 .

and that death occurred, on the date stated above, at 5 A. m.*

The CAUSE OF DEATH* was as follows: Acute gastro enteritis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) (Pertussis) Bronchopneumonia

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hanbrook M. D.

6/12 1921 (Address) 1 E Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL 6/13 1921

20 UNDERTAKER J. Finn McCulley.

ADDRESS 1306 E. Fontan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is required. TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. D. Co.—1000 Bks.

D 54452

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D 54452

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 26th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Ann Crimmins (St Agatha) (Resident)

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 83 yrs 0 mos. 17 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Year 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher - 068

(b) General nature of industry, business, or establishment in which employed (or employer) Teaching -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) George Town D.C.

PARENTS

10 NAME OF FATHER Michael Crimmins

11 BIRTHPLACE OF FATHER (city or town) Co Limerick (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Fox

12 BIRTHPLACE OF MOTHER (city or town) Co Longford (State or country) Ireland

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md.

15 JUN 12 1921 ROBERT J. BAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1890 to June 11th, 1921, that I last saw h alive on June 10th, 1921, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Chr - Endocarditis - Post Chr. Rheumatism

ebt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Terminal Dementia - Post chr mania

ebt (duration) 48 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Wheeling, W. Va

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

June 12th 1921 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Wheeling - W. Va. June 12 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Full statement of occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54453

CERTIFICATE OF DEATH.

108 C D 54453

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST.) 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Gertrude Behrend.

(Residence in Baltimore: No. 2901 Norfolk ave St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~SEX.~~ Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, 1880 Dec 10/1879 (Month) (Day) (Year)

7-AGE, 41 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Lehman Blum

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Sarah Hecht

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Behrend

(Address) 1288 W North ave

15- Filed JUN 12 1921 ROBERT I KRAUTER 191... Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8, 1921, to June 11 1921, that I saw h[illegible] alive on June 11 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Contusion - Acute

(Duration) ....yrs. ....mos. 4 ds.

(Signed) Louis Faehl M. D.

June 11, 1921 (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Hebrew Friendship DATE OF BURIAL, June 13, 1921

20-UNDERTAKER J Ahrens & Co ADDRESS 1611 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items must be carefully and fully answered. Where none exists, or cannot be obtained, or is unknown, write "None," "Unknown," or "Not Ascertained." Omission of any important information will necessitate return of certificate. See instructions on back of certificate.

Spec.—5-9-19—H. P. Co.—1000 Bks.

D 54454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 54454

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 Payson St North ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Helena Wharton

(a) RESIDENCE. NO. 1021 N. Payson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) June 10-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James L Wharton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie E. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) James L Wharton 1021 N Payson St

15 JUN 12 1921 ROBERT C. [illegible] Registrar

Burial [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1921, to June 11, 1921, that I last saw her alive on June 11, 1921, and that death occurred, on the date stated above, at 4.45 p m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Meningitis Simple (post contract)

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Geo. L Shannon M. D.

6/11. 1921 (Address) 700 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oella Cemetery	June 13 21

20 UNDERTAKER Daniel Easton ADDRESS 516 Pa ave

BURIAL CERTIFICATE MUST BE PRESENTED TO SEXTON OF CEMETERY BEFORE INTERMENT IS MADE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54455

D 54455

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3361 Chestnut Ave WARD 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Walker

(a) RESIDENCE. NO. 3361 Chestnut Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Walker

6 DATE OF BIRTH (month, day, and year) Oct 23 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John T Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret T

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Edward Walker 3361 Chestnut Ave

15 Robert P. Harrison, Registrar

UN 17 1921

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to June 9th, 1921.

That I last saw h[illegible] alive on June 9- 9.P.M. 1921.

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No General evidence

What test confirmed diagnosis? Examination of Urine

(Signed) R B Normentt, M. D.

6/10, 1921 (Address) 3142 Charlcote Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	June 13 1921

20 UNDERTAKER	ADDRESS
Chenowith & Son	Chestnut Ave

IMPORTANT: Should be carefully answered. Exact statement as to each item may be properly classified. Exact statement as to each item may be properly classified, so that it may be used for statistical purposes. Physician should state in plain terms, so that it may be used for statistical purposes. Physician should state in plain terms, so that it may be used for statistical purposes. CAUSE OF DEATH in plain terms, so that it may be used for statistical purposes. CAUSE OF DEATH in plain terms, so that it may be used for statistical purposes. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54456

81

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2216 N. Calvert ST. 17 WARD)

2-FULL NAME Caroline Mary de Marcellin

(a) RESIDENCE. No. 2216 N. Calvert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Claude A. V. de Marcellin

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1826

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	94	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Peter Stryker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER ----- Snowhill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm. H. Moffett

(Address) 2216 N. Calvert St.

15 Filed Robert P. Harrison, Registrar

JUN 10 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 12th 1920, to June 10th 1921, that I last saw h[illegible] alive on June 10th 1921, and that death occurred, on the date stated above, at 1-40 P m.

The CAUSE OF DEATH* was as follows:

Senile Arterio Sclerosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. H. Fuss, M. D.

6/11, 1921 (Address) 1216 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	6/13 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. If INFANTILE DISEASE, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54457

D 54457

CERTIFICATE OF DEATH.

39

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Ashburton ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Butts

(a) RESIDENCE. NO. 1620 Ashburton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Gonce

6 DATE OF BIRTH (month, day, and year) June 26, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	11	13	

8 OCCUPATION OF DECEASED 074

(a) Trade, profession or particular kind of work Stable foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Union Transfer Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford County Maryland

PARENTS

10 NAME OF FATHER Solomon Butts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rebecca Alvina Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. Richard W. Meyer 1620 Ashburton Street

15 Filed Robert F. Harrison, Registrar

UN 12 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to June 9, 1921, that I last saw him alive on June 9, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lip & mouth

(duration) yrs. 10 mos. 9 ds.

CONTRIBUTORY (Secondary) General toxaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) W. S. Love, M. D

19 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	6/13, 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

MAKE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54458 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54458

CERTIFICATE OF DEATH. X 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General St. Hosp. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward W. Koontz

(a) RESIDENCE. NO. Union Mills, Md ST., WARD. Union Mills Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27 1858

7 AGE 63 Years 4 Months 15 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Josiah Koontz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Bankard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Chas W. Koontz (Address) Union Mills Md

15 Filed JUN 12 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1921, to June 12, 1921, that I last saw h / M alive on June 12, 1921, and that death occurred, on the date stated above, at 6-00 a m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Obstruction of Small Intestine (duration) yrs. mos. 5 ds.

18 Where was disease contracted If not at place of death? at residence

Did an operation precede death? Yes Date of June 5/21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. F. Tepper M.D. 19 (Address) Maryland Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Silver Run Cem Carroll Co Md	June 15 19
20 UNDERTAKER	ADDRESS
H Bankard & Son	Westmin

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54459

D 54459

154

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1949 Edmondson Ave ST.: 70 WARD)

2-FULL NAME Maurice E Ward.

(a) RESIDENCE. No. 1949 Edmondson Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER Richard Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland.

12 MAIDEN NAME OF MOTHER Mary E. Toney.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Mrs Georgianna Lovell (Address) 1949 Edmondson Ave

15 Filed Nov 19 Robert P. Harrison, Registrar

N 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 5/24, 1921, to 6/11/21, 19..., that I last saw h-- alive on 6/10/21, 19..., and that death occurred, on the date stated above, at 9 45 m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Old age —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Jgm

(Signed) H. H. Maurice, M. D.

6/12, 19 (Address) 1502 N Longwood.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 14 1921

20 UNDERTAKER George J. Smith ADDRESS 2 S. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

54460
D 54460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54460

CERTIFICATE OF DEATH.

53-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3808 Fenchurch ST., 17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosario Vincent Di Giorgio

(a) RESIDENCE No. 3808 Fenchurch ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov-7 1804

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ...min.
	16	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Vincent Di Giorgio

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Italy

14 Informant Vincent DiGiorgio
(Address) 3808 Fenchurch St

15 Filed JUN 13 1921 ROBERT F. BRUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1920, to June 11, 1921;
that I last saw him alive on June 10, 1921,
and that death occurred, on the date stated above, at 12 45 a m.

The CAUSE OF DEATH* was as follows:

Hodgkins -

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Section of Gland.

(Signed) Joseph William Kelly, M. D.

, 19 (Address) 2327 Calvert Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL June 13 1921

20 UNDERTAKER Martin Fahey & Sons — ADDRESS 1827 W North Ave

mation should be carefully supplied. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54461

CERTIFICATE OF DEATH.

104 D 54461

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 S. Potomac ST.; 1, WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Warzynak

(Residence in Baltimore: No. 812 S. Potomac St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Jan. (Month) 6 (Day), 1921 (Year)

7-AGE, ...yrs. 5 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE. (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Warzynwak

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Stefana Jaronska

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Warzynwak

(Address) 812 S. Potomac St.

15- Filed JUN 13 1921, 191... ROBERT J. KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 11 (Day), 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from June 11, 1921, to June 11 1921, that I saw him alive on 6 11 1921, and that death occurred, on the date stated above, at 11 05 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. T. Kerr M. D.

6/11/21, 191... (Address) 402 S. Patterson Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, June 13, 1921

20-UNDERTAKER Stephen L. Frankowski ADDRESS, 1000 S. Kenwood Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 54462

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore & W. Va. Ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R. Brown

(a) RESIDENCE. No. 610 W. Va. ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Lillian Jenkins Brown

6 DATE OF BIRTH (month, day, and year) Oct 22 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail Carrier U.S.

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Post Office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER E. Fete Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Dudley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant E. Fenette Brown

(Address) 1524 Park ave

15 Filed JUN 13 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 12, 1921, that I last saw him alive on June 12, 1921, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcus, following septic abruption (uterus & fund T.B. of lungs last supp.)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Rectal Abscess

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1500 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill	June 14 1921
20 UNDERTAKER	ADDRESS
J. Shy Burns & Son	Towson

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be of TION is very important. See instructions on back of c

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54463

CERTIFICATE OF DEATH.

80 D 54463

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 5136 Park Heights ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Sleginniss

(a) RESIDENCE. No. 5136 Park Heights ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Esther R. Sleginniss

6 DATE OF BIRTH (month, day, and year) Nov. 1 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Oils

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co Maryland

PARENTS

10 NAME OF FATHER Wm. Sleginniss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Stumbers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wilson Sleginniss
(Address) 5136 Park Heights Av

15 Filed JUN 13 1921 ROBERT P. CHANTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1921, to June 11, 1921, that I last saw h~~im~~ alive on June 11, 1921, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

arterio-Sclerosis
angina Pectoris

~~Contributory~~ (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) angina Pectoris several hours
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at his office

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) H. Labbe Emith, M. D.

, 19 (Address) 905 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
Druid Ridge	June 14 1921

20 UNDERTAKER Geo W Little

ADDRESS 3700 Edmondson Av

mation should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Calder

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54464

CERTIFICATE OF DEATH.

120

D 54464

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2413 Francis ST.; 13 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E Calder

(Residence in Baltimore: No. 2413 Francis st St.; ..... yrs., ... mos., 2 wks ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Widower

6-DATE OF BIRTH. March 1, 1849
(Month) (Day) (Year)

7-AGE. 72 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer). 006

9-BIRTHPLACE, (State or Country). Harford Co Md

PARENTS.

10-NAME OF FATHER. Franklin Calder

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary Martin

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Little

(Address) 2700 Edmondson Ave

15- Filed JUN 13 1921 ROBERT J KRAUTER REGISTRAR. BURIAL PERMIT ISSUED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 11, 1921.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 15 1921, to June 11 1921, that I saw h[im] alive on June 11 1921, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

contributory

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O O Lord M. D.

June 12, 1921. (Address) 2222 E Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Belair Harford Co Md

19-PLACE OF BURIAL OR REMOVAL. Belair, Md

DATE OF BURIAL. June 14 1921

20-UNDERTAKER Geo. W. Little

ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact technical or scientific terms are important. See instructions on back of certificate.

Cyrus Graham

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54465

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54465

CERTIFICATE OF DEATH.

X 1

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 579 Pierce St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cyrus Graham

(a) RESIDENCE. NO. 579 Pierce St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Blk	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Graham

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Whitewashing odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

11 Informant C. C. Kelly (Address) 519 Pierce St. adds

15 Filed JUN 13 1921 19 ROBERT A. ARAILE Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6th 1921 to June 10, 1921.

That I last saw him alive on June 9th 1921.

and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Gustav Weltmann M. D.

19 (Address) 656 W. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery

20 UNDERTAKER: Jno. M. Johnson

DATE OF BURIAL: June 13 1921

ADDRESS 1204 Eutaw St.

mation should be carefully supplied. All items must be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of c

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54466 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54466

CERTIFICATE OF DEATH. 40

REGISTERED NO. 15

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3418 Pinkney St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Brainger

(a) RESIDENCE. NO. 3418 Pinkney ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Brainger

6 DATE OF BIRTH (month, day, and year) June 26 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 073

(b) General nature of Industry, business, or establishment in which employed (or employer): R.R. Buyer

(c) Name of employer: agent

9 BIRTHPLACE (city or town) (State or country): Louisville Ky

PARENTS

10 NAME OF FATHER: W. H. Brainger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Louisville Kentucky

12 MAIDEN NAME OF MOTHER: Emily Buechner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Indiana

14 Informant (Address): Jno. D. Rodgers Jr. 4024 Belleau

15 Filed JUN 13 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1920, to June 12, 1921, that I last saw him alive on June 4, 1921, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Paralysis agitans

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Ronald V. Abercrombie, M. D.

Jan 13, 1921 (Address) 18 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Orleans La

DATE OF BURIAL: June 14 1921

20 UNDERTAKER: Wm. Tavenner & Sons

ADDRESS

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPAT CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54467 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54467

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 344 - E - 22 ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Young Knighton

(a) RESIDENCE. NO. 344 E - 22 St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth A Knighton

6 DATE OF BIRTH (month, day, and year) Dec 25 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	16	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Life Insurance

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Prudential Ins Co Baltimore Md

PARENTS

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Harry A Knighton

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Harriett Parr

13 BIRTHPLACE OF MOTHER (city or town) New York (State or country)

14 Informant O'Connors (Address) 1613 Mt Royal Ave

15 Filed ..... 19 ..... Registrar

JUN 13 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6 1919, to June 10 1921, that I last saw him alive on June 10 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis
Hemoplegia 6 months ago.
Hydr- aortic sclerosis. Mania c convulsions (duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) [redacted] (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine. Aortic sclerosis -

(Signed) Irving Miller, M. D.

, 19 (Address) 108 E. Needle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	June 13 1921

20 UNDERTAKER Paul F Kerner & Son ADDRESS North Ave

Should be carefully supplied. CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54468

D 54468

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1513 Lafayette ave. ST.; 16 WARD)

2-FULL NAME Eleanor M White

(a) RESIDENCE. No. 1513 Lafayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wells M White

6 DATE OF BIRTH (month, day, and year): May 31 1836

7 AGE: Years 85 Months 0 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Vermont

PARENTS

10 NAME OF FATHER: Daniel Dexter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Vermont

12 MAIDEN NAME OF MOTHER: Rosalana Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Vermont

14 Informant: Mrs Daniel McCullough

(Address): 1413 Bolton St

15 Filed JUN 13 1921 ROBERT J. BRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 14 1919, to June 10 1921, that I last saw h— alive on June 7 1921, and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) Jno L Schnauff M. D.

(Address) 2317 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: 6/13/21

20 UNDERTAKER: W H Tatum & Son — ADDRESS: Penn-Mottler

mation should be carefully supplied. Avoid abbreviations. Write it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D 54469

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54469

45

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 r Mt Royal St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Joseph Sawyer Raborg

(a) RESIDENCE. No. 120 r Mt Royal St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Florence Raborg

6 DATE OF BIRTH (month, day, and year) Sept 25 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Christopher T Raborg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann McGowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Kathryn Lester

(Address) 120 r Mt Royal

15 Filed ....., 19 ..... Registrar

JUN 13 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June —, 1920, to June 12, 1921.

that I last saw him alive on June 12, 1921.

and that death occurred, on the date stated above, at 7 am m.

The CAUSE OF DEATH* was as follows:

Cancer of Prostate

About (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard M. D.

, 19 (Address) 1E Centre St Balt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Jun 14 1921
20 UNDERTAKER	ADDRESS
J Scott Fox	North

N. B. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. Fractions of a day, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54470

1040 54470

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Katherine Roeder

(a) RESIDENCE. NO. 1603 Darley Av. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Mr. John F. Roeder.

6 DATE OF BIRTH (month, day, and year) Jan. 25 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Thos. Roeder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Leonard Roeder (Address) 1603 Darley Av

15 Filed JUN 13 1921 19 ROBERT I. KNUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1921; to June 13, 1921.

that I last saw her alive on June 12 1921.

and that death occurred, on the date stated above, at 2.50 a.m.

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia.

(duration) yrs. mos. 21. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 7. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 26 21.

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) D. J. Cassagneo, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL June 15 1921

20 UNDERTAKER Henry Hoerth Son — ADDRESS 1301 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY in years, months and days. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Size 6-52-B 1000 Bks.

D 54471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54471

REGISTERED NO. 104

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 501 Fredrick ave ST. Brooklyn WARD)

2-FULL NAME James Ellsworth Lowman

(a) RESIDENCE. NO. 501 Fredrick Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	white	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 23/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	0	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ ood

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltto (State or country) Md.

PARENTS

10 NAME OF FATHER Arthur Lowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Laura B. Acker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Arthur Lowman. (Address) 501 Fredrick ave.

15 Filed JUN 13 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10. 1921

17 I HEREBY CERTIFY, That I attended deceased from May 28. 1921. to June 10. 1921., that I last saw him alive on June 9 1921., and that death occurred, on the date stated above, at 10 15 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William D. Foth, M. D.

June 10. 1921 (Address) 816 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL (2-Pm) June 13. 1921

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St

N. B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Riley 1639 Fr Barcalow

D 54472

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54472

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH. (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

CITY OF BALTIMORE (No. Enos Ave and Front ST.: 12 WARD)

2-FULL NAME Otto E. Jeremias

(Residence in Baltimore: No. 2344 Barcaly Street ST.: 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Sept 13, 1860 (Month) (Day) (Year)

7-AGE. 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Harness Mak

(b) General nature of industry, business, or establishment in which employed (or employer). Master

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amanda M. Jeremias

(Address) 2344 Barcaly St.

15-JUN 13 1921 Filed ..... 191.....

ROBERT I. BRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 11, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, an Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. heart

Dont know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Carl Clay M. D. (Coroner.)

June 12, 1924. (Address) 1639 Enos Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Woodlawn

DATE OF BURIAL. June 14 1921

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

R. S. Every item of information should be given in answer to each question, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54473

CERTIFICATE OF DEATH.

D 54473

X 115

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. 34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick A Smith

(a) RESIDENCE NO. US. Public Health Hosp. #56, Baltimore Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. PENCIL NOT TO BE USED. AGE should be carefully supplied. OCCUPATION should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH. Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25 yrs.	--	--	

8 OCCUPATION OF DECEASED Sailor 086

(a) Trade, profession or particular kind of work --

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer Ireland

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T Rosenbrock Registrar
(Address) US. PHS Hosp. #56 McHenry Md.

15 Filed ....., 19 ..... Registrar

JUN 13 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1921, to June 11 1921.

that I last saw h. alive on June 11 1921, 19 Am.

and that death occurred, on the date stated above, at 5'30 a m.

The CAUSE OF DEATH* was as follows:

Pleurisy suppurative

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Abscess liver

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of **

Was there an autopsy? No

What test confirmed diagnosis? Exam. Lab report

(Signed) H. Reichard, M. D.

June 11, 1921 (Address) US. PHS Hosp #56 Pass Surgeon Fort McHenry MD

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — DATE OF BURIAL June 13 1921

20 UNDERTAKER Sol Levinson — ADDRESS 112 E Balto St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
Abscess of liver.
No further history.

Ellis M. Shuman

Stamp Co. 1000 Blks.

D 54474

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54474

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hosp. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon M. Ellis

(a) RESIDENCE. NO. 215½ E. Pratt ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prussia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prussia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prussia

14 Informant Mrs H. Lipsitz

(Address) 1503 E. Baltimore St.

15 Filed JUN 13 1921 Bureau of Vital Statistics Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12-21 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-8 1921, to 6-12 1921, that I last saw him alive on 6-12 1921, and that death occurred, on the date stated above, at 11.25 a.m.

The CAUSE OF DEATH* was as follows:

Nephritis & Toxemia

CONTRIBUTORY (Secondary) Prostatic Hypertrophy duration yrs. 2 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Bamberger M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL June 13 1921

ADDRESS 1127 E Baltimore St

20 UNDERTAKER Maf Levinson

Be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be mation should be carefully supplied. AGE should be carefully classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54475

CERTIFICATE OF DEATH.

X 50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 N. Charles ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Effie Erma Cullin

(a) RESIDENCE. No. Crisfield, Md. ST.. WARD. Crisfield Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. D. Travers Cullin

6 DATE OF BIRTH (month, day, and year) Jan 26 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Crisfield Md

PARENTS

10 NAME OF FATHER Edw. Miester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Crisfield Md

12 MAIDEN NAME OF MOTHER Annie Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Crisfield Md.

14 Informant (Address) J. Travers Cullin Crisfield Md.

15 Filed JUN 13 1921 19 Burial permit issued by Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1921.

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to June 13, 1921.

that I last saw her alive on June 13, 1921.

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 12 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of June 8, 1921

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Samuel L. Magners, M. D.

(Address) 1206 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rem. Crisfield Md.	June 16 1921
20 UNDERTAKER	ADDRESS
F. A. Frazier & Son	708 Hanover St

N. B.—BRIEF ENTRIES. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should make prompt returns. Information should be carefully supplied. AGE should be carefully supplied. OCCUPATION should be properly classified. Exact statement of OCCUPATION of deceased should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Patient was operated on
about 4 days ago
at Presbyterian Eye & Ear
Hospital for deflected
septum of nose.
S. L. Mayerson.

Form —6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 54476

D 54476

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 242 N Arlington Ave ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Waddy

(a) RESIDENCE. NO. 242 N Arlington Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Col'd

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~) Frank Waddy

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE Years 34 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va Living Balt. 27 years

PARENTS

10 NAME OF FATHER Jim Mead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Irrethia Yearly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Frank Waddy

(Address) 242 N Carlington Ave

15 JUN 13 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1921, to June 10, 1921, that I last saw h alive on June 7, 1921, and that death occurred, on the date stated above, at 9 1 m

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Jun. 10 21 (Address) 937 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL. June 14 1921

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Av

N. B.—WRITE LEGIBLY. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54477 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D 54477

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lee

(a) RESIDENCE. No. 814 N. Dallas St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed JUN 13 1921 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1921. to June 9, 1921. that I last saw h im alive on June 9, 1921. and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis, hypertension.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test

(Signed) Patterman M. D.

6/7/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetry	June 13. 1921
20 UNDERTAKER	ADDRESS 1725
Wm R. A Elliott	Ashland Ave

N. B.—WRITE PLAINLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54478

40 D 54478

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 637 N. Lakewood Ave ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Velencovsky

(a) RESIDENCE. NO. 637 N Lakewood Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Velencovsky

6 DATE OF BIRTH (month, day, and year): 1853

7 AGE: Years 68; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Vaclav Barou

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): John Velencovsky 637 N Lakewood Ave

15 Filed ....., 19 ..... Registrar

JUN 13 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1921, to June 11, 1921, that I last saw h alive on June 11, 1921, and that death occurred, on the date stated above, at 8:40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Howard, M. D.

Jan 12, 19 22 (Address) 1801 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 14 1921

20 UNDERTAKER: Frank Brockbank — ADDRESS: 1916 Eastlands

---

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54479

CERTIFICATE OF DEATH.

108 D 54479

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.: N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Koubek, Antonia

(Residence in Baltimore: No. 3920 Fremwood Ave St.: ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1 (Year)

7-AGE, 36 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Petr

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Josephin Petricks

13-BIRTHPLACE OF MOTHER (State or Country), Bohemi

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Koubek

(Address) 820 N. Macdonough

15- JUN 13 1921 (Date received) ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1 (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1921, to June 11 1921, that I saw her alive on June 11 1921, and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:

Post-operative Peritonitis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Lake D. Lee M. D.

6-11-21 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary — DATE OF BURIAL, June 14, 1921

20-UNDERTAKER Frank Cruchon — ADDRESS 906 Eastlake

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Remarks Appendicitis

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma." "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis.*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21 M&T 1500 Bks.

Walter L Carlin

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54480

CERTIFICATE OF DEATH.

X/20 D 54480

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH US. Public Health Hosp. #66

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. 24 WARD)

2-FULL NAME Walter L Carlin

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., Baltimore Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Walter L Carlin

6 DATE OF BIRTH (month, day, and year): un known

7 AGE — Years: 27 yrs. Months: - Days: - If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED: Painter 050

(a) Trade, profession or particular kind of work: Painter

(b) General nature of Industry, business, or establishment in which employed (or employer): --

(c) Name of employer: ---

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edgar T Rosenbrock Registrar (Address): US. Public Health Hosp. #66

15 Fort McHenry Md.

Filed JUN 13 1921, 19 ROBERT J. KRAUSS Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17 1921, 19 ..... to June 10 1921 .....

that I last saw him alive on June 10 1921, 19 .....

and that death occurred, on the date stated above, at 1'00 pm.

The CAUSE OF DEATH* was as follows:

Nephritis chronic interstitial

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Uremic poisoning

(duration) - yrs mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Exam. Lab report

(Signed) J D Reedmond M. D.

6/2/19 (Address) U.S. P.H.S. 56 Ft McH Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 14 1921

20 UNDERTAKER: Frank A. Fink — ADDRESS: 918 N. Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should note that information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

D 54481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54481

CERTIFICATE OF DEATH.

REGISTERED NO. C 182

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital or on way to ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Mentz

(Residence in Baltimore: No. 1111 Ashland Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 1, 1877
(Month) (Day) (Year)

7-AGE, 44 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): Grocer

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, H. Mentz

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Mary Effing

13-BIRTHPLACE OF MOTHER (State or Country). Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Mentz

(Address) 1111 Ashland Ave

15- JUN 13 1921 191 ROBERT J. BRADLEY Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) held June 16 '21 thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in chest (own)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

June 17, 1921. (Address) 1637 Key

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, June 15 1921

20-UNDERTAKER Frank A. Tesch ADDRESS 910 N. Gay St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

June 16 - History of having been "held up" and shot - P. M was made by Dr. M. Cleary and report cause of death June 17, 21 U. S. Rec

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urænia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 54482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54482

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 N. Rutland ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J. Taylor

(a) RESIDENCE. NO. 1006 N. Rutland ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene J. Taylor

6 DATE OF BIRTH (month, day, and year) Dec 5 1820

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John E. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr J. Taylor (Address) 1006 N. Rutland ave

15 Filed JUN 13 1921 ROBERT P. KRUTZER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 11 1921, that I last saw h[illegible] alive on June 11 1921, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Endocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) 6 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas E. Smith M. D.

, 19 (Address) 1616 E 4 St Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	June 14 1921

20 UNDERTAKER Henry Lutz ADDRESS 1007 N. Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be filled out in duplicate. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54483

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54483

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Jefferies

(a) RESIDENCE. No. 8th st., Fairfield, Md. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 627

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Atkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Myda Fields

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JUN 13 1921 19 ROBERT J. [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to June 12, 1921.

that I last saw her alive on June 12, 1921.

and that death occurred, on the date stated above, at 3.05 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) T. H. Cairney M. D.

6-13-21 (Address) Municipal Tuberculosis Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 14 1921
20 UNDERTAKER John H. Toadvine	ADDRESS [illegible]

N. B.—WRITE PLAINLY. All the items, including AGE should be stated EXACTLY. PHYSICIANS should be careful in stating the mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 54484

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54484

CERTIFICATE OF DEATH.

154

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 N. Charles St. ST.: 17 WARD)

2-FULL NAME Sylvia L. Hunt

(a) RESIDENCE. No. 1825 N Charles St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? 70 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 / 1829

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Johnstown Pa

PARENTS

10 NAME OF FATHER Enoch Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Eliza Bagerly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Englewood

14 Informant Grace H Crawley (Address) 1825 N Charles Stdaughter

15 Filed JUN 13 1921 . 19 ROBT. I. DAVIES Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from at Same time during last 2 or 3 yrs, 19 to June 10th, 19 21, that I last saw h[illegible] alive on June 10th, 19 21, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Senile degeneration Especially of brain due to hardening of Coronary arteries, Related to for a year or two (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Same that caused death (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) H. C. Harrison, M. D.

, 19 (Address) 31 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	June 13 1921

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1827 N North Ave

N. B.—ARTIFICIAL LIMBS. Any person having suffered the amputation of a limb should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54485

D 54485

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 Light St. ST.: 23 WARD)

2-FULL NAME Lorraine Griffith

(a) RESIDENCE. NO. 1926 Light St. ST., 24 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 0 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 27 1921

7 AGE — Years — Months — Days: 15 — If LESS than 1 day, hrs. or mns.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Guy Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Q Annes

12 MAIDEN NAME OF MOTHER: Helen Rush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Guy Griffith 1926 Light St

15 Filed JUN 13 1921 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1921, to June 11, 1921, that I last saw h alive on June 11, 1921, and that death occurred, on the date stated above, at 7 11 m.

The CAUSE OF DEATH* was as follows:

Prematur Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. E. Campbell, M. D.

(Address) 1047 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: June 13 1921

20 UNDERTAKER: Wm J E Evans — ADDRESS: 1428 Charles St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54486

CERTIFICATE OF DEATH.

49 D 54486

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1936 E Lombard ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Link

(a) RESIDENCE. NO. 1936 E Lombard ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 11 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER John A Link

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Mary Weinberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant John Link
(Address) 1936 E Lombard

15 Filed JUN 13 1921 ROBERT E [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1921, to June 12, 1921, that I last saw h[illegible] alive on June 11, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Accuracy (Scarlatina)

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene L. Pessagno M. D.

June 12, 1921 (Address) Eugene L. Pessagno

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 13 1921
20 UNDERTAKER	ADDRESS
Wendell D. Appel Sr.	313 N

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54487

87 D 54487

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Coyne

(a) RESIDENCE. No. 608 S. Register St ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5/12 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed JUN 13 1921 ROBERT J. BAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1921, to June 11, 1921, that I last saw her alive on June 10, 1921, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral thrombosis.

(duration) yrs. 6 ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No special test

(Signed) R. H. Coman, M. D.

6/11/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patricks — DATE OF BURIAL: June 17, 1921

20 UNDERTAKER: Kendall & Lipp — ADDRESS: 37 Lemmon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54488

CERTIFICATE OF DEATH.

37-091 D 54488

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 13 Taylor st (ST.:) 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris E. Gordon.

(a) RESIDENCE. NO. 13 Taylor st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Harry Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elsie M Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant H. Gordon
(Address) 13 Taylor

15 Filed JUN 13 1921 19 ROBERT I. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to June 11, 1921, that I last saw him alive on " " , 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Sues

(duration) — yrs. — mos. 22 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

(Address) 1223 N. Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Baltimore Cemetery June 13 1921

20 UNDERTAKER — ADDRESS

George J. Ruth 735 Hanover

N. B.—WRITE PLAINLY WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54489

CERTIFICATE OF DEATH.

79 D 54489

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5210 Wilton Heights Ave ST.: 27 WARD)

2-FULL NAME Alexander Bryson Hatton

(a) RESIDENCE. NO. 5210 Wilton Heights Ave (Arlington) ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Elsie M. Hatton

6 DATE OF BIRTH (month, day, and year) Sept. 17, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	43	8	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman for 066
(b) General nature of industry, business, or establishment in which employed (or employer) City Dairy Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. C. Hatton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales Pa

14 Informant Elsie M. Hatton
(Address) 5210 Wilton Heights Ave

15 Filed JUN 15 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 12, 1921, that I last saw him alive on June 12, 1921, and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral endocarditis

(duration) 10 yrs. to my knowledge mos. ds.

CONTRIBUTORY (Secondary) Chronic endocarditis

(duration) 10 yrs. to my knowledge mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) C. B. Emsor, M. D.

6-13-1921 (Address) 5016 Park Hgts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	June 15 1921
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1948 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

091

79-D 54490

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Johns Hopkins Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Edith Shaw

(a) RESIDENCE. NO. 515 Aisquith St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Shaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sara Bar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) 2. Hd. Records

15 Filed JUN 13 1921 ROBERT E. LAMITZE Registrar

Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1921, to June 13, 1921, that I last saw her alive on June 13, 1921, and that death occurred, on the date stated above, at 6:50 a m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis & insufficiency

Myocardial insufficiency

~~Pulmonary edema~~

(duration) 16 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema. Broncho-pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? in Russia

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Mason, M. D.

6-13-21, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rockdale — DATE OF BURIAL June 14 19 21

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E. Balto. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

43 D 54491

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

54491

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 Pennington ave ST.; 13 WARD)

2-FULL NAME Hattie Bejhrand

(a) RESIDENCE. NO. 804 Pennington ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Capt Aiden Beckter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jack Leuris

(Address) 1411 Baltimore st

15 Filed JUN 13 1921 19.. BURIAL PERMIT Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12- 1921

17 I HEREBY CERTIFY, That I attended deceased from May ..., 1920, to June 12 1921,

that I last saw her alive on June 12 1921,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Metastases

Anemia (duration) 1 yrs. mos. ds.

18 Where was disease contrarted if not at place of death?

Did an operation precede death? yes Date of May 1917

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) C Ustan Smith, M. D.

, 19 (Address) 877 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew — DATE OF BURIAL: June 14 1921

20 UNDERTAKER: Jack Leuris — ADDRESS: 1411 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PUBLIC RECORD. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. mation should be properly classified. so that it may be CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Era Udovitch

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54492

CERTIFICATE OF DEATH.

91 — D 54492

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Udovitch, Era

(Residence in Baltimore: No. 731(S) E. Pulaski St. St.; 20 yrs., mos. da.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 14 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham Fayelson

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Anna —

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs.

(Address) 1711 E. Baltimore St.

15- JUN 13 1921 Filed ....., 191.... ROBERT B. KRAUSE Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1921, to June 12 1921, that I saw her alive on June 12 1921, and that death occurred, on the date stated above, at 9:55 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, Brain Abs.

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Streptococcus infection

(Duration) 1 yrs. ..... mos. 13 ds.

(Signed) Chas. S. Law, M.D.

June 17, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 10 ds. In the State 20 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 37 E. Pulaski St

19-PLACE OF BURIAL OR REMOVAL, Mount Mt. Carmel — DATE OF BURIAL, June 14, 1921.

20-UNDERTAKER Jacob Louis — ADDRESS 1411 E. Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54493 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54493

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Vincent Infant Asylum Street 14th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Spence

(a) RESIDENCE. NO. St Vincent Infant Asylum ST. 14th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 7 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Spence

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant St Vincent Infant Asylum
(Address) 1401 Division St

15 Filed ... 19... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 10, 1921, that I last saw him alive on June 10, 1921, and that death occurred, on the date stated above, at 10 10 Am m.

The CAUSE OF DEATH* was as follows:

ORN

Bronchial Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? See Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. S. Hollander, M. D.

(Address) 15 W McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 13 1921
20 UNDERTAKER A. Fahey & Son	ADDRESS 1820 W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JN 13 1921

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Cool mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54494

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54494

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 932 Lemon St ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Fullum

(a) RESIDENCE. NO. 932 Lemon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	M.

5a If married, ~~widowed or divorced~~ ~~HUSBAND~~ of (or) WIFE of Joseph Fullum

6 DATE OF BIRTH (month, day, and year) Aug 25 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Charleston S C

PARENTS

10 NAME OF FATHER Henry Hemmit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosie Zerpol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Joseph Fullum

(Address) 932 Lemon St

15 Filed JUN 13 1921 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 10, 1921, to June 12, 1921, that I last saw h[illegible] alive on June 12, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? None (Physical)

(Signed) J. Thaston Lee. M. D.

6/13, 1921 (Address) 888 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL June 1921

UNDERTAKER J. Pearce Low ADDRESS 913 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS' should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54495 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54495

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 538 E. Clements St. 3rd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Brewer,

(a) RESIDENCE. No. 538 E. Clements St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~Wife of~~ Annie D Brewer

6 DATE OF BIRTH (month, day, and year) Dec. 5, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bailer maker.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER Wm. Brewer

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Amey

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Annie D Brewer (Address) 538 Clements

15 Filed JUN 13 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 11, 1921, that I last saw him alive on June 10, 1921, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Pinhoma L Lines

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Wm. T. Seabury, M. D.

6/12 1921 (Address) 638 Ford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: June 13 1921

20 UNDERTAKER: E. D. Fanning & Son — ADDRESS: 460 Battery Ave.

D 54496 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54496

CERTIFICATE OF DEATH.

REGISTERED NO. C 150

PLACE OF DEATH

CITY OF BALTIMORE (No. 224 N. Gay ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Effie M. Farrall

(Residence in Baltimore: No. 224 N. Gay St.; yrs., mos., da.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Sgl

6-DATE OF BIRTH, June (Month) 8 (Day), 1911 (Year)

7-AGE. ....yrs. 5 mos. ....da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. ———
(b) General nature of industry, business, or establishment in which employed (or employer). ———

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Clinton Farrall

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Nellie Leach

13-BIRTHPLACE OF MOTHER (State or Country), N. York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. N. Farrall

(Address) 224 N. Gay

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 13 (Day), 1911 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....by death on the day stated above.

The CAUSE OF DEATH* was as follows:

Spinal Bifida

3 — (Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....da.

(Signed) Walter Riley M. D. (Coroner.)

June 13, 1911 (Address) 10 E. Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Thomas DATE OF BURIAL, June 15 1911

20-UNDERTAKER Lane Cook ADDRESS 503 E. Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CERTIFICATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54497

120

D 54497

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Madison ave ST.: 14 WARD)

2-FULL NAME Gussie Ritzler

(a) RESIDENCE. NO. 1810 Madison ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, ~~or Divorced~~ (write the word): Widowed

6 If married, widowed, or divorced (~~HUSBAND~~ of) (or) WIFE of: Gustave J Ritzler

6 DATE OF BIRTH (month, day, and year): Dec 12

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Hotel

(b) General nature of industry, business, or establishment in which employed (or employer): Proprietor 084

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maine

PARENTS

10 NAME OF FATHER: ? Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Frank P. Day

(Address): 1810 Madison

15 Filed . 19 Registrar

Via P R R. C/o Frank P Day

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1921, to June 12, 1921, that I last saw her alive on June 11, 1921, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A Grey, M. D.

. 19 (Address) 1603 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount cemetery Baltimore Md

DATE OF BURIAL: June 15 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E Madison

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54498

CERTIFICATE OF DEATH.

151 D 54498

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1537 E. Fayette (St.) 19 (Ward)

2-FULL NAME Baby McCoy

(a) RESIDENCE. No. 1537 E. Fayette St.. Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed~~, or Divorced (write the word)
Male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, / hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not any 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Rosie McCoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dun N. C

12 MAIDEN NAME OF MOTHER Daisy Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) White Spring N. C

14 Informant
(Address)

15 Filed Robert P. Harrison, Registrar

JUN 13 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1921

17 I HEREBY CERTIFY, That I attended deceased from on June 10, 1921, to , 19 ; that I last saw h[illegible] alive on June 10, 1921, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

6-11-1921 (Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19/13
20 UNDERTAKER	ADDRESS
Commissioner Health	

Per. Wm. E. WOOD[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54499

CERTIFICATE OF DEATH.

80 D 54499

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1941 W Fayette St. 20 WARD)

2-FULL NAME Rose A. McNulty (Apt)

(a) RESIDENCE. No. 1941 W Fayette St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement may be made on back of certificates. See instructions on back of certificates. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement may be made on back of certificates. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John J McNulty

6 DATE OF BIRTH (month, day, and year): June 11 1859

7 AGE — Years: 61 — Months: 11 — Days: 30 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None 700
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Jno Mungeley

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Sarah O'Hare

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Miss A McNulty
(Address): 1941 W Fayette

15 Filed 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1921, to June 10, 1921.
That I last saw h[illegible] alive on June 10, 1921.
and that death occurred, on the date stated above, at 7:10 a.m.

The CAUSE OF DEATH* was as follows:
Angina pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic arteriosclerosis

Edema (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

(Signed) Edw Newkam M. D.

6/13, 1921 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 6/14/21

20 UNDERTAKER: Geo A Fahy Sutton — ADDRESS: Fayette

JUN 13 1921

Spec.—8-24-14—M. & T.—2000 Blks.

D 54500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54500

CERTIFICATE OF DEATH.

H 2

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Rosedale & ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Augusta Handley

(Residence in Baltimore: No. 1629 Rosedale & St.: 50 yrs., 8 mos. — ds.)

WRITE PLAINLY, with ink or indelible pencil. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (~~Write the word.~~)
Female	White	Married

6-DATE OF BIRTH, October (Month) 11 (Day), 1864 (Year)

7-AGE, 56 yrs. 8 mos. — ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wife 037
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, John Reider

11-BIRTHPLACE OF FATHER (State or Country), Berks Penna

12-MAIDEN NAME OF MOTHER Elizabeth Weigel

13-BIRTHPLACE OF MOTHER (State or Country), Augusta Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ~~J. Harry Handley~~ W. Harry Hey

(Address) 1926 Rosedale St.

15-

Filed ... Robert P. Harrison, ... Registrar.

JUN 13 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1920, to June 11 1921, that I saw h ~~er~~ alive on June 11 1921, and that death occurred, on the date stated above, at 6.20 2 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) A. D. Goldsmith M. D.

June 11, 1921. (Address) 2100 N. North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery

DATE OF BURIAL, June 13, 1921

20-UNDERTAKER W M Routson

ADDRESS 2238 N Mt

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54501

D 54501

CERTIFICATE OF DEATH.

X 51

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Thelma Miller

(a) RESIDENCE. No. Grafton W. Va. ST., WARD. Grafton W. Va.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18 - 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER James Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Maud Durbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Hospital Record

(Address) J. H. H.

15 Filed . 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

JUN 13 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 - 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13 . 1921 . to June 13 - . 1921 .

that I last saw her alive on June 13 - . 1921 .

and that death occurred, on the date stated above, at 1:45 p. m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre

Symptoms marked for

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contrarted if not at place of death? Grafton, W. Va

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Victory.

(Signed) H. H. Carter, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grafton W. Va	June 13 1921
20 UNDERTAKER John O Mitchell	ADDRESS 120 W Saratoga

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 54502

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 D 54502

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1930 Walbrook Ave. ST. 15th WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME Anna L. East

(Residence in Baltimore: No. 1930 Walbrook Ave St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5 ~~SINGLE, MARRIED~~ WIDOWED ~~OR DIVORCED~~ (If rite the word): Widow

6-DATE OF BIRTH: Sept. (Month) 12 (Day), 1847 (Year)

7-AGE: 72 yrs. 9 mos. — ds. If LESS than 1 day, ~~X~~ hrs. or ~~min.~~?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Gibson

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Gibson

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. C. Everett Auld
(Address) 1930 Walbrook Ave.

15- Robert P. Harrison,
Filed 191 Burial Permit Clerk.
JUN 13 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12th, 1921, to June 17 1921, that I saw h~~er~~ alive on June 11, 1921, and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Sarcoma of Spinal Cord

(Duration) 3 yrs. — mos. — ds.

Contributory (SECONDARY) General Paralysis

(Duration) 5 yrs. 6 mos. — ds.

(Signed) Wm. Grant M. D.
6/12, 1921 (Address) 2226 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cem. DATE OF BURIAL: June 14, 1921

20-UNDERTAKER: Margaret G. Flynn ADDRESS: 1422 Light St.

D 54503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54503

CERTIFICATE OF DEATH.

REGISTERED NO. C 108

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1311 Andre St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Nicholas F. Burg.

(Residence in Baltimore: No. 1311 Andre St.)

16 ------- (St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, September 24th. 1898., 1 (Month) (Day) (Year)

7-AGE, 22 yrs. 8 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Piano worker.
(b) General nature of industry, business, or establishment in which employed (or employer): 0.K.

9-BIRTHPLACE, (State or Country), Austria.

PARENTS.

10-NAME OF FATHER, Michael Burg.

11-BIRTHPLACE OF FATHER (State or Country). Austria.

12-MAIDEN NAME OF MOTHER Agathia Weil.

13-BIRTHPLACE OF MOTHER (State or Country), Austria.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Burg. (wife)

(Address) 1311 Andre St.

15- Filed JUN 13 1921, 191 Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Gangrenous Appendicitis.

(Duration) ....yrs....mos....ds.

(Signed) Hoke Eastland M. D. (Coroner.)

June 13 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross a.a.	June 15th 1921
20-UNDERTAKER Marg. J. Lehmann	ADDRESS 1422 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

D 54504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54504

CERTIFICATE OF DEATH.

44

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 N. Conn ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Moore

(Residence in Baltimore: No. 320 N. Conn St ST.; 78 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. April 3 (Month) (Day), 1843 (Year)

7-AGE. 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Susan Not known

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie Myers

(Address) 1722 Mulliken St

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

JUN 13 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1919, to June 11 1921, that I saw her alive on June 8 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Epithelioma

Contributory Malignant Ulcer

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) S. G. Cordell M. D.

June, 1921 (Address) 1204 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Cemetery

DATE OF BURIAL, June 17 1921

20-UNDERTAKER Daniel Coskin

ADDRESS 916 Eutaw

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21 M&T—1500 Bks.

D 54505

HEALTH DEPARTMENT—CITY OF BALTIMORE

8,091

D 54505

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 Vincent ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Pitts

(a) RESIDENCE NO. 504 Vincent ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. Life ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Aug. 22, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Pitts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lettie Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant William Pitts

(Address) 504 Vincent St.

15 Filed JUN 13 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to June 13, 1921.

that I last saw her alive on June 13, 1921.

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. 1 mos. , ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) William Fry M. D.

6/13, 1921 (Address) 1928 Pa. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 14 1921
20 UNDERTAKER Richard H. Curley	ADDRESS 2016 Barclay St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 54506 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54506

CERTIFICATE OF DEATH.

REGISTERED NO. C 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Hanover ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Klump

(Residence in Baltimore: No. 1621 Hanover St. 37 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, April 6, 1869. (Month) (Day) (Year)

7-AGE, 52 yrs. 1 mos. 6 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Carpenter 015 (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germy

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germy

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Klump

(Address) 1621 Hanover.

15- Robert P. Harrison, ..., 191.... Registrar.

JUN 13 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 9th, 1921, to June 12th, 1921, that I saw him alive on June 12th, 1921, and that death occurred, on the date stated above, at 4 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Aortic insufficiency of Heart

(Duration) yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. Immediate mos. ds.

(Signed) Harry Neidle M.D.

6/13, 1921 (Address) 224 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, June 15, 1921

20-UNDERTAKER E. Schloman & Son ADDRESS 1039 Hanover st

WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54507

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54507

CERTIFICATE OF DEATH.

79

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 Harlem Av ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August W. E. Derlin

(Residence in Baltimore: No. 802 Harlem ave. St.; 64 yrs.. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug. (Month) 17 (Day), 1841 (Year)

7-AGE, 79 yrs. 9 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Musician
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Ernest Deflin

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Wilhemine

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna L. Deflin

(Address) 802 Harlem Ave

15- Robert P. Harrison,

Filed....., 191.... Burial Permit Clerk, Registrar.

JUN 13 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 5. 1921, to June 13 1921, that I saw h[illegible] alive on June 13 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pericarditis

Dilated heart

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Old age

(Duration) 1 yrs.....mos.....ds.

(Signed) Geo. A. Bennett M. D.

June 13, 1921 (Address) 802 Harlem Ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL Baltimore DATE OF BURIAL, June 16, 1921

20-UNDERTAKER Geo. W. Little ADDRESS 711 Edmondson

Spec.—1-10-21—M&T—1500 Blks.

D 54508

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54508

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1412 Hanbert ST., 24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Winter

(a) RESIDENCE NO. 1412 Hanbert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 18 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	24	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laboring 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER John Winter
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant M. Sakodynsky
(Address) 1412 Hanbert St

15 JUN 13 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

E. G. Man 827 N Eutaw St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to June 13, 1921, that I last saw h— alive on June 13, 1921, and that death occurred, on the date stated above, at 3 45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia
Coma

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. F. Starr M. D.

6-13, 1921 (Address) 827 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill DATE OF BURIAL June 16 1921

20 UNDERTAKER W. Cahoon ADDRESS 502 E North Ave

MARGIN RESERVED

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54509 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54509

CERTIFICATE OF DEATH.

8-09

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1604 N. Durham ST.) 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Percy

(Residence in Baltimore: No. 1604 N Durham St. Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, July (Month) 27 (Day), 1920 (Year)

7-AGE, 11 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Millard F. Percy

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Lucy E Dietrich

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Millard F Percy

(Address) 1604 N Durham St

15- Filed JUN 19 1921, 191. Robert P. Harrison, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6 1921, to June 13 1921, that I saw h N alive on June 13 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Whooping cough

(Duration) yrs. mos. ds.

(Signed) Jacob Fisher M. D.

June 13, 1921. (Address) 1823 N. Mast. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cem't

DATE OF BURIAL, June 17, 1921

20-UNDERTAKER W. E. Oak

ADDRESS 502 E Northern

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Eli Aldridge

D 54510 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54510

CERTIFICATE OF DEATH

1-PLACE OF DEATH Volunteers of America Hosp. REGISTERED NO. 120

CITY OF BALTIMORE: (No. 418 W. Lexington ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eli aldridge

(a) RESIDENCE. No. 418 W. Lexington ST. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Aldridge

6 DATE OF BIRTH (month, day, and year) July 19 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Union Co North Carolina

PARENTS
10 NAME OF FATHER William Aldridge
11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.
12 MAIDEN NAME OF MOTHER Millie Baker
13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Elizabeth Aldridge (Address) 418 W. Lexington St.

15 Filed JUN 13 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13-1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28 1921, to June 13 1921, that I last saw h[illegible] alive on June 13 1921, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Edema of the Lungs (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. F. Pettigrew M. D.
6 13, 1921 (Address) 418 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Hill S. C. DATE OF BURIAL June 14 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. Northave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS will be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54511

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54511

CERTIFICATE OF DEATH.

154

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S. Monroe ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad F. Murbach

(Residence in Baltimore: No. 105 S. Monroe St.: 56 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH, June (Month) 15 (Day), 1836 (Year)

7-AGE, 84 yrs. 11 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Soap maker 86
(b) General nature of industry, business, or establishment in which employed (or employer): Soap manufacture

9-BIRTHPLACE, (State or Country), Switzerland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Amelia Albrecht

(Address) 105 S. Monroe St.

15- Robert P. Harrison,

Filed JUN 13 1921 191 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to June 12, 1921, that I saw h[illegible] alive on June 11, 1921, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Carcinoma

(Duration) 5 yrs. mos. da.

(Signed) E. F. Preston M. D.

June 13, 1921. (Address) 14 W. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, June 14 1921

20-UNDERTAKER Chas. G. Black ADDRESS 742 W. Fort Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54512

CERTIFICATE OF DEATH.

150 D 54512

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hansen

(a) RESIDENCE. NO. 4901 E. Donnell St Canton WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	14.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick Hansen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Anna Bolley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co

14 Informant Hospital Record (Address)

15 Filed JUN 14 1921 ROBERT I. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 . 1921 . to June 13 . 1921 . that I last saw h alive on June 13 . 1921 . and that death occurred, on the date stated above, at 8 50 a m

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Pneumococcus Bronchialis)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) W. E. Davison, M. D.

19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Cemetery	June 14 1921
20 UNDERTAKER	ADDRESS
A. Sander & Sons	1710 Eliot St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54513

CERTIFICATE OF DEATH

93 D 54513

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: NO. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Rochen

(a) RESIDENCE. NO. 1732 E. 28th ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42.	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland. Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hospital (Address) Balto, Md.

15 Filed JUN 14 1921 ROBERT I. KRAUTER Registrar Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1921

17

I HEREBY CERTIFY, That I attended deceased from June 4, 1921, to June 11, 1921,

that I last saw h alive on June 11, 1921

and that death occurred, on the date stated above, at 11.00 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Febrinous Pleurisy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Finding

(Signed) H. Goldsmith M. D.

6/12/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. St Matthews Cem. DATE OF BURIAL. June 15 1921

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Carrie Jones

Spec.—8-24-14—M. & T.—2000 Bks.

D 54514 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54514

CERTIFICATE OF DEATH.

REGISTERED NO. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 722 Byrd St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Jones

(Residence in Baltimore: No. 722 Byrd St.) (If under 1 yr., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE, 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Viola Washington

(Address) 722 E Byrd St

15-

Filed JUN 14 1921 ROBERT J. BRAUER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11th, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18th 1921, to June 11th 1921, that I saw h- alive on June 10th 1921, and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (Duration) ..... yrs. 5 mos. ..... ds.

(Signed) A. Jos Ellis M. D.

6/13, 1921 (Address) 722 E Byrd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, June 14, 1921

20-UNDERTAKER A. L. Brown & Son ADDRESS 10 W. Monty

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54515 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54515

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Carter's Sanatorium Bellona ave Towson ST. ..... WARD)

2-FULL NAME Jessie Elizabeth Shaw

(a) RESIDENCE. NO. 2807 W North ST. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm T. Shaw

6 DATE OF BIRTH (month, day, and year) Oct 6 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Justus Kaufer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Wm T Shaw 2807 W North ave

15 Filed JUN 14 1921 19 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4 1921 to June 12 1921.

that I last saw her alive on June 11 1921.

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Hemorrhage

Hemiplegia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondacy) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo F Sargent, M. D.

, 19 (Address) Towson Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	June 15 19
20 UNDERTAKER W J Gutmann Sons	ADDRESS North & Pa

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54516

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2715 Belair Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas F. Maher

(a) RESIDENCE. NO. 2715 Belair Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Maher

6 DATE OF BIRTH (month, day, and year) June 21st 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman for 086

(b) General nature of Industry, business, or establishment in which employed (or employer) Building Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Maher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Alice Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs. Elizabeth Maher

(Address) 2715 Belair Ave.

15 Filed JUN 14 1921 19 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1920, to June 13, 1921.

that I last saw him alive on June 12 1921.

and that death occurred, on the date stated above, at 10:00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Duodenal Ulcer

Heart Disease

(duration) 15 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) John A. Fiddes M.D.

6/15/21 (Address) 1566 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: June 16 1921

20 UNDERTAKER: Henry Hoech Son — ADDRESS: 1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2/3

Form 6-9-19 H P Co—1000 Blks.

D 54517

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54517

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Penitentiary ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Tysoe

(a) RESIDENCE. NO. 3511 Roland Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper. OH 5

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Maryland.

PARENTS

10 NAME OF FATHER George W. Tysoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Kate Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Patrick J. Brady (Address) 1114 Pine St

15 Filed JUN 14 1921 ROBERT P. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-13 1921

17 I HEREBY CERTIFY, That I attended deceased from April-26 1921, to June-13 1921, that I last saw him alive on June-12 1921, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation-
Edema of Lungs
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis
(duration) yrs. 1 mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Examination.

(Signed) William F. Schwarz M. D.

June 13 1921 (Address) Md. Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden.

DATE OF BURIAL 6/15 1921

20 UNDERTAKER Conwell & Son.

ADDRESS 361 Eastern

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

106 D 54518

CERTIFICATE OF DEATH.

D 54518

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 Christian ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hermansdorfer

(a) RESIDENCE. No. 1923 Christian ST. 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 11 mos. ds. How long in U. S., if of foreign birth? 52 yrs 11 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Barbara Hermansdorfer

6 DATE OF BIRTH (month, day, and year) Sept 10 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bayreuth Germany

PARENTS

10 NAME OF FATHER John Hermansdorfer

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant H. J. Hermansdorfer (Address) 1923 Christian St

15 Filed JUN 14 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 8th, 1921, to June 13, 1921.

That I last saw h... alive on June 12, 1921, and that death occurred, on the date stated above, at 5-10 a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. Greenbaum, M. D.

6/13, 1921 (Address) 517 Lucas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 15 1921

20 UNDERTAKER John B. Spencer ADDRESS 1325 N. Caroline St.

MARGIN RESERVED

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54519

CERTIFICATE OF DEATH.

X 28-10 D 54519

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 225 S. Durham St.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virgil Bales

(a) RESIDENCE. NO. 225 S. Durham ST., WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ed Bales

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Albert Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lily Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Lilly Holland (Address) 225 S. Durham

15 Filed JUN 14 1921, 19 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from April 20 1921, to June 11, 1921, that I last saw h. alive on June 11, 1921, and that death occurred, on the date stated above, at 12 M. p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Lungs

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Va

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. P. Burns, M. D.

(Address) 2221 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	June 14 1921
20 UNDERTAKER John W. Henderson	ADDRESS 1502 E. Monument

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54520

CERTIFICATE OF DEATH.

10-091 D 54520

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 608 S. Greene St ST.; 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorotha Lawson

(a) RESIDENCE. No. 608 S. Greene ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Lawson

6 DATE OF BIRTH (month, day, and year) Dec. 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thos. Netter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto - Md

12 MAIDEN NAME OF MOTHER Barney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto - Md

14 Informant Wm Lawson (Address) 608 S. Greene St

15 Filed JUN 14 1921 19.. ROBERT E. [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1. 1921 to June 12. 1921

that I last saw h alive on June 11. 1921

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows: (a) Broncho. Pneumonia

10 days. Contrib. La Grippe.

Acute Myocarditis, Acute Cardiac dilatation (duration) 3 months

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None -

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) H. C. Feinberger M.D.

(Address) 682 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	June 19
20 UNDERTAKER	ADDRESS
Frank Scott Hooper	801 W Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54521

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2625 Lehman ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Coelen

(a) RESIDENCE. NO. 2625 Lehman ST.: 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 11-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. min.
		8 mos	under	1 day

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Coelen

11 BIRTHPLACE OF FATHER (city or town) Frederick Co Md (State or country)

12 MAIDEN NAME OF MOTHER Sarah Reindollar

13 BIRTHPLACE OF MOTHER (city or town) Jones Town Md (State or country)

14 Informant Thomas L. Collins

(Address) 2625 Lehman St.

15 JUN 14 1921 REGISTRAR [illegible]

Registered June 9 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1921, to June 11, 1921, that I last saw him alive on June 11, 1921, and that death occurred, on the date stated above, at 3 8 m.

The CAUSE OF DEATH* was as follows:

8 month

under Exclusion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

Congestion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theo. T. Koldewey, M. D.

(Address) 12. 34 So Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mont Olivet	June 13 1921
20 UNDERTAKER	ADDRESS
Geo. L. Schwab & Bro	2101 Eutaw Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54522

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 54522

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2002 E. Lombard ST.: V WARD)

2-FULL NAME Catharine Bitters

(a) RESIDENCE. No. 2002 E. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Bitters

6 DATE OF BIRTH (month, day, and year) Nov. 4/1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Ahles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Christian Bitters 2002 E. Lombard st.

15 Filed JUN 14 1921 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1921 to June 13 1921.

That I last saw h[illegible] alive on June 11 1921.

and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sarcoma of liver (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no.

What (est confirmed diagnosis? Clinical

(Signed) A. C. Bracey, M. D.

6/13. 1921 (Address) 1600 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 5 1921
20 UNDERTAKER	ADDRESS
Jos J. Burr	156 N. Luzerne

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54523

Spencerian Pen Co.—1000 Bks.

D 54523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 N. Eden ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmora Smith

(a) RESIDENCE. No. 621 N. Eden ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	—	—	

8 OCCUPATION OF DECEASED Housework

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vienna Md

PARENTS

10 NAME OF FATHER John Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant: Edward Smith (Address) 621 N Eden St

15 JUN 14 1921 ROBERT I. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11/21 19

17 I HEREBY CERTIFY, That I attended deceased from 6/8/21 . 19 . to 6/11/21 . 19 .

that I last saw her alive on 6/10/21 . 19 .

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert H. Levy M. D.

6/11/21 (Address) 1207 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: June 14 19 21

20 UNDERTAKER: P B Groth — ADDRESS: 1425 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

David Thomas

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54524

CERTIFICATE OF DEATH.

12 D 54524

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bay view Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Thomas

(Residence in Baltimore: No. 513 Burgundy Alley St.; 31 yrs. / mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1822 (Year)

7-AGE, 49 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Saloon
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country). South Carolina

PARENTS.

10-NAME OF FATHER, Monday Thomas

11-BIRTHPLACE OF FATHER (State or Country). S. Carolina

12-MAIDEN NAME OF MOTHER Emma Williams

13-BIRTHPLACE OF MOTHER (State or Country). South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records

(Address) Bay view Hospital

15-

FILED JUN 14 1921 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Diffuse Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Trauma

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Coroner. M. D.

6/12/21, 191.. (Address) 1003 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL. June 15 1921

20-UNDERTAKER P. C. Gross

ADDRESS 1405 McElderry St

N. B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54525

HEALTH DEPARTMENT—CITY OF BALTIMORE

92D 54525

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Light St.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wells

(a) RESIDENCE. NO. 1612 Light ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 9 day 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman 073

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R. R. Balto. Md

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER August Wells.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto - Md.

12 MAIDEN NAME OF MOTHER Eliz. Arnold.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Annie Mc Kay (Address) Hebrew Hospital.

15 Filed JUN 14 1921 19 [illegible] Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5 . 1921 , to June 11 . 1921 , that I last saw h— alive on June 11 . 1921 , and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) W. T. Seabury , M. D.

6/13 1921 (Address) 638 Font

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL June 14 1921

20 UNDERTAKER J. J. Fahey & Son. ADDRESS 1318 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54526

D 54526

CERTIFICATE OF DEATH.

REGISTERED NO. C 119

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 4008 Maine Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Haywood Fulenwider

(Residence in Baltimore: No. 4008 Maine Ave St.; 13 yrs. — mos. — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, January (Month) 5 (Day), 1873 (Year)

7-AGE. 48 yrs. 5 mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Traveling salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country). Shelby N C.

PARENTS.

10-NAME OF FATHER. Eli Fulenwider

11-BIRTHPLACE OF FATHER (State or Country). Shelby N C.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Forest Fulenwider

(Address) 4008 Maine Ave

15- Filed JUN 14 1921, 191.... ROBERT J. BRAUTIGAM Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 12th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 11th 1921, to June 12th 1921, that I saw him alive on June 12th 1921, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

Duration

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(Duration) ....yrs. ....mos. 5 ds.

(Signed) A. C. Swanson M. D.

June 13th, 1921 (Address) 4 S Ed J Gardenville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cemetery	June 15, 1921
20-UNDERTAKER	ADDRESS
Harry R Armacost	1204 Ridgewood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 54527

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54527

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 N. Carey ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Everett & Edith Watkins

(a) RESIDENCE NO. 1113 N Carey ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 13/21

7 AGE	Years	Months	Days	If LESS than 1 day, 12 hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ovd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Everett Watkins

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Edith Simmons

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Everett Watkins
(Address) 1113 N Carey St

15 JUN 14 1921 ROBERT J. BRUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1921, to June 14, 1921, that I last saw him alive on June 13, 1921, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. William Frey, M. D.

6/14, 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL June 14 21

20 UNDERTAKER Thomas & Dennis

ADDRESS 1303 Pennsylvania Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D 54528

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3631 Falls Rd. ST.: 13 WARD)

2-FULL NAME Mary A. Foster

(a) RESIDENCE. No. 3631 Falls Road ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Solomon D. Foster

6 DATE OF BIRTH (month, day, and year): Aug. 21-1827

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Maryland

PARENTS

10 NAME OF FATHER: Geo. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co. Maryland

12 MAIDEN NAME OF MOTHER: Hannah Breland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Hannah Stevens
(Address): 3619 Hickory Ave.

15 Filed JUN 14 1921 ROBERT B. KRAUTH Registrar

Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1921, to June 12, 1921, that I last saw her alive on June 11, 1921, and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

(Old Age) - Senile Dementia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Colles fracture

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo W Wells M. D.

(Address) 2020 N. Charles 6/13 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — DATE OF BURIAL: June 15 1921

20 UNDERTAKER: Horace F. Burgee — ADDRESS: 363 Falls Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fell while walking across floor. Physician states that primary cause of her death was "old age" rather than fall

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54529

HEALTH DEPARTMENT—CITY OF BALTIMORE

D) 54529

63-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.) 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Greenwood Curtis

(a) RESIDENCE. No. 1429 Short ~~Alley~~ ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Susan Chew

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed JUN 14 1921 . 19 ROBERT A KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1921

17

I HEREBY CERTIFY, That I attended deceased from May 28, 1921, to June 13, 1921.

that I last saw her alive on June 15, 1921.

and that death occurred, on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis agitans

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia. (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Wassermann special test

(Signed) V. Wasserman, M. D.

6/14/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	June 16 21
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	46 N. Caroline St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54530

CERTIFICATE OF DEATH.

151 D 54530

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 N. Central Ave ST.; 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Catherine & Preston J. Ritter

(a) RESIDENCE. No. 1028 N Central Av ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 Hours How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				4 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Preston J. Ritter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Horstmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Preston J. Ritter (Address) 1028 N Central Ave.

15 Filed JUN 14 1921 19 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17

I HEREBY CERTIFY, That I attended deceased from June 13th, 1921, to June 13th, 1921, that I last saw h[illegible] alive on June 13th, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth.

6 hr. Month

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Carmel Cemetery June 1921

20 UNDERTAKER — ADDRESS

Jos Schnitzius Waller 2334 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54531

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54531

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital ST.: 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel M. Trenary

(Residence in Baltimore: No. 2905 Garrison ave St(yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Sept (Month) 26 (Day), 1867 (Year)

7-AGE: 53 yrs. 8 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman 66
(b) General nature of industry, business, or establishment in which employed (or employer): machinery

9-BIRTHPLACE, (State or Country): Ill

PARENTS.

10-NAME OF FATHER: James Trenary

11-BIRTHPLACE OF FATHER (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or Country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Evelyn Trenary

(Address) 2905 Garrison Ave.

15- JUN 14 1921 ROBERT J. KRAUTER

Filed ....., 191.... Clerk

Burial 6/14/21 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull

Struck by Street Car

accident (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Intra Cranial

Contusion (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) James M. Rawlins (Coroner.) M. D.

June 14, 1921. (Address) 704 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 14 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Richmond V. Frederick Rd

Former or usual residence 2905 Garrison Ave.

19-PLACE OF BURIAL OR REMOVAL: Ottawa, Ill.

DATE OF BURIAL, 6/14, 19 21

20-UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert St

Via Penn. Railroad - Escort Mrs. Evelyn Trenary

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 54532 HEALTH DEPARTMENT—CITY OF BALTIMORE

150 D 54532

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1109 Carson Court ST. 16 WARD)

REGISTERED No C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelius Ed. King

(Residence in Baltimore: No. 1109 Carson Court St.; yrs., mos. 5 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, May 16, 1921 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 2 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boy 000.
(b) General nature of industry, business, or establishment in which employed (or employer): (Orphan)

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. John King

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Etta Queen

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John King

(Address) 1109 Carson Court

15- FILED JUN 14 1921 BY ROBERT J KRAUTER Registrar. Serial No. 14 Block

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) did that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration) yrs. mos. 2 8 ds.

CONTRIBUTORY (Secondary) Concussion of

(Duration) yrs. mos. 2 8 ds.

(Signed) Jos. D. Hennessy M. D. (Coroner)

June 13th 1921 (Address) 2817 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	June 14. 1921
20-UNDERTAKER Daniel Easton	ADDRESS 916 Pine

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Kathryn Knowlton

HEALTH DEPARTMENT—CITY OF BALTIMORE

54533

CERTIFICATE OF DEATH.

175-001 D 54533

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. University Hospital St. 9 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Knowlton

(Residence in Baltimore: No. 1913 Homewood ave — St. 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, Feb (Month) 25 (Day), 1915 (Year)

7-AGE, 6 yrs. 4 mos. 15 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balt City

PARENTS.

10-NAME OF FATHER: Saul J. Knowlton

11-BIRTHPLACE OF FATHER (State or Country): Maine

12-MAIDEN NAME OF MOTHER: Adalaide Bemer-

13-BIRTHPLACE OF MOTHER (State or Country): Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel J. Knowlton

(Address) 1913 Homewood Ave

15-

Filed JUN 14 1921 ROBT. J. [illegible]

Burial Permit Issued [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jun (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull.

(Duration) ..... yrs. a few hours mos. ds.

CONTRIBUTORY (Secondary) Struck by Automobile.

(Duration) ..... yrs. a few hrs. mos. ds.

(Signed) W. H. Forman (Coroner.) M. D.

Jun 14 1921 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: New Castle Lincoln Co Maine — DATE OF BURIAL: June 16 1921

20-UNDERTAKER: William Post — ADDRESS: 1723 W. Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

D 54531

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54534

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH, CITY OF BALTIMORE (No. Church Home St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sidney Ludwig

(Residence in Baltimore: No. 1920 E. Balto St. St.: 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1916
(Month) (Day) (Year)

7-AGE, 5 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Harry Ludwig

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Kay Davis

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Ludwig

(Address) 1920 E. Balto St.

15- Filed JUN 14 1921, 191.... ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Motor Accident

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) yrs. mos. ds.

(Signed) Geo. W. Wade M. D.
(Coroner.)

June 14, 191... (Address) 143 N. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Arbutus Cemetery — DATE OF BURIAL, June 14 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E. Balto

over.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54535

CERTIFICATE OF DEATH.

X 50 D 54535

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2532 Edmondson Ave; 16th WARD)

REGISTERED No. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Linolan Riland

(Residence in Baltimore: No. 2532 Edmondson Ave; ..... yrs., ... mos. 21 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	Married

6-DATE OF BIRTH. Oct 31, 1860 (Month) (Day) (Year)

7-AGE. 60 yrs. 7 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter 073
(b) General nature of industry, business, or establishment in which employed (or employer): Conductor U.R.R.

9-BIRTHPLACE, (State or Country): Halifax, Pa

PARENTS.

10-NAME OF FATHER. Paul Jones Riland

11-BIRTHPLACE OF FATHER (State or Country). Penn.

12-MAIDEN NAME OF MOTHER. Mary Gilbert

13-BIRTHPLACE OF MOTHER (State or Country). Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Riland

(Address) 2532 Edmondson Ave

15- JUN 14 1921 [illegible] Clerk

Filed....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 12, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1921, to June 12 1921; that I saw him alive on June 12 1921; and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Tetanus, Intestitial nephritis

(Duration) 20 yrs. ..... mos. ..... dys.

CONTRIBUTORY (Secondary) Diabetes mellitus

(Duration) 12 yrs. ..... mos. ..... dys.

(Signed) John L. Riland M. D.

June 12, 1921 (Address) 1219 Hopkins Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. 21 ds. In the State ..... yrs. ..... mos. 21 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Halifax Pa

19-PLACE OF BURIAL OR REMOVAL. Westernport — DATE OF BURIAL. 6-14-, 1921

20-UNDERTAKER H. C. Bramming & Son — ADDRESS 5 T.N. Schroeder St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54536

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby ~~Baby~~ Wilson

(a) RESIDENCE. No. 1900 Lanvale St ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs 5 mos Life ds. How long in U. S., if of foreign birth? yrs mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 - 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
			1 - 2 hrs	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) JHH Records.

15 Filed JUN 14 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1921, to June 11, 1921,

that I last saw h Lr alive on June 11, 1921,

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Birth
Cerebral Hemorrhage
(Birth Injury)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) C W Barron, M. D.

6-12, 1921 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS JUN 13 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54537

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

93 D 54537

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 422 S. Bouldin ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Blessing

(a) RESIDENCE. No. 422 S. Bouldin ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Samuel Blessing

6 DATE OF BIRTH (month, day, and year) Mch. 17. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Harvey Frostburg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Ellen Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Mrs. Cecelia Will

(Address) 422 S. Bouldin St.

15 Filed

19 Robert P. Harrison, Registrar

Burial Permit Clerk.

UN 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 9 , 1921, to June 12 , 1921, that I last saw h— alive on June 11 , 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chron

Acute Endocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Weinland, M. D.

(Address) 422 S. Bouldin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 15 1921
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

14677 / 54538

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54538

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.) 8 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. H. Pritchard (Pritchard)

(a) RESIDENCE. No. 2609 E. Monument St. (St.) (Ward.)
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Husband of Louise Pritchard

6 DATE OF BIRTH (month, day, and year) Feb. 4. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. Factory 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Geo. Pritchard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anne Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Next Friend.

15 Filed . 19 Registrar

Robert T. Harrison, Burial Permit Clerk.

N14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17

I HEREBY CERTIFY, That I attended deceased from June 11 . 1921 . to June 13 . 1921 .

that I last saw him alive on June 13 . 1921 .

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Septicemia. Cavernous sinus thrombosis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Retropharyngeal abscess.

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? Baltimore.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) E. W. Brady. M. D.

6-13 1921 (Address) Johns Hopkins.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dallo Cemetery	June 17 1921
20 UNDERTAKER	ADDRESS
Robt. Turner Sr.	424 N. Bway.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54539

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54539

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital (15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Nathan Ulman.

(a) RESIDENCE. NO. 24 Talbot Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Dinah Ulman

6 DATE OF BIRTH (month, day, and year) Oct 27/1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Retired. 043

(b) General nature of industry, business, or establishment in which employed (or employer) Wholsale Liquor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Mr. Joseph Ulman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Simpsheyt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records
(Address)

15 Filed JUN 14 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7 1921 to June 13 1921.

That I last saw him alive on June 13 1921.

and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:

Adynamic Ileus.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum

(duration) yrs. mos. 6. ds.

18 Where was disease contracted if not at place of death? 24 Talbot Road.

Did an operation precede death? Yes Date of June 7-21

Was there an autopsy? No

What test confirmed diagnosis? Operation & Autopsy

(Signed) N. N. Sartorius, M. D.

June 13 1921 (Address) U. M. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sheb Shalom	June 15 1921
20 UNDERTAKER	ADDRESS
Wm. Sondheim	118 N. Mt Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

148 748
D 54540

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54540

CERTIFICATE OF DEATH.

X 74

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Winnifred Webster

(a) RESIDENCE. NO. Sault St Marie, Mich. WARD. Sault St. Marie Mich.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of W E H Webster Same address

6 DATE OF BIRTH (month, day, and year) Dec 30 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ontario

PARENTS

10 NAME OF FATHER Jas Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ontario

12 MAIDEN NAME OF MOTHER Mary Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ont

14 Informant Hospital Record
(Address) J H H

15 Filed JUN 14 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to June 13, 1921, that I last saw her alive on June 13, 1921, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

1 Brain Tumor

(duration) Several mos. ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. E. Mundy, M. D.

6-14, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Toronto Canada	June 14 1921

20 UNDERTAKER ADDRESS John O'Mitchell 1201 N. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54541

D 54541 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 47

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Reilly

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28th WARD. Washington D. C.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? Never Knew mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married~~ widowed, ~~or divorced~~
~~HUSBAND of~~
(or) WIFE of Mr Reilly

6 DATE OF BIRTH (month, day, and year) Aug 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas McGrath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt H. Slater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Balto md

15 Filed JUN 14 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 23rd, 1921, to June 14th, 1921, that I last saw h[er] alive on June 13th, 1921, and that death occurred, on the date stated above, at 2.55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

abt (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia Post Senile Mania

abt (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

June 14th, 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C

DATE OF BURIAL 6/14 1921

20 UNDERTAKER Henry W. Means & Son

ADDRESS 1052 N Calvert St

JUN 14 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54542

CERTIFICATE OF DEATH.

37 D 54542

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 W. Hill ST.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Kerney

(a) RESIDENCE. NO. 214 W. Hill ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Kerney

6 DATE OF BIRTH (month, day, and year) ——— 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Noah Miller

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sydia Brockenburg

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Virginia.

14 Informant. William Kerney (Address) 214 W Hill St.

15 Filed ..... 19.....

JUN 14 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov, 10, 1920, to June, 13, 1921, that I last saw her alive on June, 13, 1921, and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Syphilis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Consultation

(Signed) Dan Trumbo M. D.

6/14 1921 (Address) 1211 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va.	June 15 1921
20 UNDERTAKER Samuel L Kennedy	ADDRESS W Broad

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54543

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54543

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 601 Pierce ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Sutton

(Residence in Baltimore: No. 601 Pierce St. 50 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, Unknown ..... (Month) ..... (Day) ....., 1851 (Year)

7-AGE, 70 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Westminster Md

PARENTS.

10-NAME OF FATHER, Peter Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rachel Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Sutton

(Address) 601 Pierce St

15-

Filed ....., 19..... Registrar.

JUN 14 1921 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June ..... (Month) ..... 12th (Day) ....., 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2d 1921, to June 12 1921, that I saw h.. alive on June 11th 1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

..... 07142
..... Gastritis
..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Paralysis
..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) ..... M. D.

June 13 1921. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, June 14, 1921

20-UNDERTAKER, Daniel J Hennessy ADDRESS 1128 Bank St

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Remarks

Apoplexy cerebral hemorrhage

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54544

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54544

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: WARD)

REGISTERED NO. 108-091

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Carr

(a) RESIDENCE. No. Raleigh Apts 2nd St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	B.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant P. Morton Chase (Address) 1400 Mosher

15 Filed JUN 14 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/11 1921, to 6/13 1921, that I last saw h[illegible] alive on 6/13 1921, and that death occurred, on the date stated above, at 1145p m.

The CAUSE OF DEATH* was as follows:

Acute Suppurative Cystitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6/11/21

Was there an autopsy? No

What test confirmed diagnosis? Oper. & Autopsy.

(Signed) Unclear, M. D.

6/13, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md	6/14/21 19
20 UNDERTAKER	ADDRESS
Samuel W. Chase Son	1400 Mosher St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 54545 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54545

CERTIFICATE OF DEATH. X 60

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hosp ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cesques Louise Hoff

(a) RESIDENCE. NO. Marietta Ohio R F D ST.. WARD. Marietta Ohio

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11-1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER Edwin E Hoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Goldie Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio.

14 Informant Hospital Record (Address) J H H

15 Filed JUN 14 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1921

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to June 14, 1921, that I last saw her alive on June 14, 1921, and that death occurred, on the date stated above, at 7 00 A m.

The CAUSE OF DEATH* was as follows:

Pyuria 2 yrs (non-specific)
Brain abscess

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/21/21

Was there an autopsy? No

What test confirmed diagnosis? Newton & Guard

(Signed) Lindsay & Bruce, M. D.

6/14, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Marietta, Ohio	June 14- 1921

20 UNDERTAKER ADDRESS

Jack Lewis, 1411 E Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54546

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 E. Fort Ave. ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helma Hilbinger.

(a) RESIDENCE. No. 600 E. Fort Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. 5 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Dec, 30, 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John H. Hilbinger.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Fannie C. Nily.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore. Md.

14 Informant (Address) Mrs. Augusta A. Otterbein (aunt) 600 E. Fort Ave.

15 Filed JUN 14 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14th 1921.

17 I HEREBY CERTIFY, That I attended deceased from June, 1st. 1921. to June 14th. 1921.

that I last saw her alive on June 14th. 1921.

and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Otto M. Reinhardt M. D.

June 1914 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 15 1921

20 UNDERTAKER	ADDRESS
George J. Ryan	1735 Hanford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spmc.—6-9-19—H. P. Co.—1000 Bks.

D 54547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54547

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Cliff. Ave. St. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Kuppenbenger

(a) RESIDENCE. NO. 1403 Cliff. Ave. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore C. Md

PARENTS

10 NAME OF FATHER Joseph Kuppenbenger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore C. Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Michael Kuppenbenger
(Address) 1403 Cliff Ave.

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

N 14921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 13, 1921, that I last saw h.. alive on June 11, 1921, and that death occurred, on the date stated above, at 6.20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Contracted)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Symptoms

(Signed) Edward Neuscaberger, M. D.

9/7. 14 (Address) 24 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Joseph Cemty Texas Md.	June 15 1921
20 UNDERTAKER	ADDRESS
Geo J Ruth	1735 Hanover Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54548

CERTIFICATE OF DEATH.

100 D 54548

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 3035 O'Donnell (St.) 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Leo Karlinsky

(a) RESIDENCE. No. 3035 O'Donnell St., Ward. Life

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ray Karlinsky

6 DATE OF BIRTH (month, day, and year) Sept. 30 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hyman Karlinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie Shapiro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Julius Mintz (Address) 400 Equitable Bldg

15 JUN 15 1921 ROBERT J. KRAVITZ, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1. 1921. to June 13. 1921.

That I last saw h alive on June 13. 1921.

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute tonsilites (Streptococcic)

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Endocarditis (Acute)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles S. Coote M. D.

June 18 1921 (Address) 503-05 S. Third St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Sholom Cemetery — DATE OF BURIAL: 6/15/21 19

20 UNDERTAKER: Jack Lewis — ADDRESS: 1411 E. Baltimore St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54549 40 D 54549

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1637 ST.: Aisquith 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Kilchenstein

(a) RESIDENCE NO. 1637 ST.: Aisquith WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or, ~~WIFE~~ of) Genevive Kilchenstein

6 DATE OF BIRTH (month, day, and year) February 19 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tile setter

(b) General nature of industry, business, or establishment in which employed (or employer) 082

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John J. Kilchenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Parr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Genevieve Kilchenstein

(Address) 1637 Aisquith St

15 Filed JUN 15 1921 ROBERT I KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1921

17

I HEREBY CERTIFY, That I attended deceased from May 9, 1921, to June 15, 1921, that I last saw h[illegible] alive on June 15, 1921, at 2 10 A. m. and that death occurred, on the date stated above, at 2 10 A. m.

The CAUSE OF DEATH* was as follows:

Stenosis of the Oesophagus (duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Roentgen.

(Signed) [illegible] M. D.

June 16 (Address) 1313 W Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: June 17 1921

20 UNDERTAKER: Henry Hoeck & Son — ADDRESS: 1301 E Eager St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write properly classified. Exact statement of OCCUPATION may be of CAUSE OF DEATH in plain terms, so that it may be of certificates. See instructions on back of TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54550 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54550

CERTIFICATE OF DEATH.

REGISTERED NO. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 E Fayette ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret T. Pugh

(Residence in Baltimore: No. 1911 E Fayette St.; yrs., mos. 3 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. June 12, 1921
(Month) (Day) (Year)

7-AGE. ...yrs. ...mos. 2 ...da. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Wm J Pugh

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Anna Fetherolf

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Pugh

(Address) 128 N. Gilmor St.

15-

Filed JUN 15 1921 191... ROBERT T KERR Registrar.

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH June 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 12 1921, to June 14 1921, that I saw h[illegible] alive on June 14 1921 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Syphilis

(Duration) ...yrs. ...mos. 2 ...da.

CONTRIBUTORY (Secondary) .....

(Duration) ...yrs. ...mos. ...da.

(Signed) F T Perry M. D.

6-14, 1921 (Address) 800 N. Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Oak Lawn Cemetery

DATE OF BURIAL. June 16, 1921.

20-UNDERTAKER Henry Lutz

ADDRESS 1007 N. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spasc—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54551

CERTIFICATE OF DEATH.

X 1 D 54551

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Gardner

(a) RESIDENCE. NO. Perryville Md ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male.	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 9 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) Off

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. E. Gardner

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Bigham

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co (State or country) Maryland

14 Informant Geo. E Gardner (Address) 2ed Conn Road Catonsville Md

15 Filed JUN 15 1921 NOTED & FILED Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13- 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7 . 1921 . to June 13 . 1921. that I last saw h— alive on June 13 . 1921. and that death occurred, on the date stated above, at 8 20 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis L Kenney . M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem Md	June 16 1921

20 UNDERTAKER William Cook ADDRESS 502 E Fayette

N. B.—WHILE PLAINLY WITH UNFADING INK—THIS FORM IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54552

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH German Aged Home

CITY OF BALTIMORE: (No. Baltimore Hayson ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeannette M. Muschette

(a) RESIDENCE. NO. Baltimore Hayson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 8 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan 22, 1840

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co Md

PARENTS

10 NAME OF FATHER John H Muschette

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Alice Barre

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co Md

14 Informant Records of Norman Aged Home (Address) Baltimore & Hayson Sts

15 Filed JUN 15 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to June 14th, 1921, that I last saw her alive on June 13th, 1921, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John H Ouff, M. D.

, 19 (Address) 1443 N Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
La Plata Charles Co Md	Jun 16 1921

20 UNDERTAKER Jos B Clark ADDRESS 103 W Balto St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54553

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54553

CERTIFICATE OF DEATH.

154

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 North Caroline ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George P. Holland

(a) RESIDENCE. No. 1709 North Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married widowed, or divorced HUSBAND of (or) WIFE of Margaret H. Holland

6 DATE OF BIRTH (month, day, and year) Feb. 7th 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 016

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor and

(c) Name of employer Builder (Self)

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Jane Flinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Ernest Kirby
(Address) 1709 N. Caroline St.

15 Filed JUN 15 1921 [illegible] Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17

I HEREBY CERTIFY, That I attended deceased from January 12, 1921, to June 12, 1921, that I last saw h[illegible] alive on June 6, 1921, and that death occurred, on the date stated above, at 10:20 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilitation. Gastritis & Infirmities age

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Infirmities of age

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? [illegible] Date of —

Was there an autopsy? [illegible]

What test confirmed diagnosis? Clinical

(Signed) O B Carman, M. D.

6-12 1921 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	June 15 1921
20 UNDERTAKER	ADDRESS
Jos B Cook	1003 N Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54554

CERTIFICATE OF DEATH.

28 D 54554

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3524 Cedar ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna B. Kisner

(Residence in Baltimore: No. 3524 Cedar ave St.; 19 yrs., 2 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Apr 9, 1902 (Month) (Day) (Year)

7-AGE. 19 yrs. 2 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Mill Hand
(b) General nature of industry, business, or establishment in which employed (or employer)..... 046

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. George C. Wehner

11-BIRTHPLACE OF FATHER (State or Country). Balto Co

12-MAIDEN NAME OF MOTHER. Ida M Whitmore

13-BIRTHPLACE OF MOTHER (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Ida M. Wehner

(Address) 3524 Cedar Ave

15- JUN 15 1921 ROBERT J. KRAUTER

Filed....., 191... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1921, to June 13th 1921, that I saw her alive on 11th June 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. S. Hammer M. D.

June 14th, 1921. (Address) 1929 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 11 mos. ....ds. In the State 19 yrs. 2 mos. 4 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Balto Co

19-PLACE OF BURIAL OR REMOVAL. Mt Zion U B Church DATE OF BURIAL, June 16, 1921

20-UNDERTAKER P. S. Marshall ADDRESS 953 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54555

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 So. Bond ST.; 3rd WARD)

2-FULL NAME JOHN PLUM,

(a) RESIDENCE. No. 714 So. Bond ST., 3 rd. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred II yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8-1910,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	II	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Plum,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland,

12 MAIDEN NAME OF MOTHER Mary Kuratka,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Mary Plum, (Father)
(Address) #714 So. Bond Street

15 Filed JUN 15 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13- 1921.

17 I HEREBY CERTIFY, That I attended deceased from Jan- , 1921, to June- 13-, 1921.

that I last saw h— alive on June 13 , 1921.

and that death occurred, on the date stated above, at 11.20p m.

The CAUSE OF DEATH* was as follows:

Valvular - Cardiac Dis—

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) A. Fibrin - Chorea

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) [illegible] M. D.

. 19 (Address) 125 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	June 16th 1921.
20 UNDERTAKER M. J. Sadowski.	ADDRESS 705 S. Ann

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54556

CERTIFICATE OF DEATH.

43 D 54556

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Cathedral St ST.: 11 WARD)

2-FULL NAME Mary A Cosiell

(a) RESIDENCE. No. 518 Cathedral St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or ~~Divorced~~ (write the word): Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Alvin Cosiell

6 DATE OF BIRTH (month, day, and year): Oct 7 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): A. A. Co Md

PARENTS

10 NAME OF FATHER: Dr Thomas J Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country): A. A. Co Md

12 MAIDEN NAME OF MOTHER: Emerald Sutton

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Maryland

14 Informant: Dr Hardy

(Address): 518 Cathedral St

15 Filed JUN 15 1921 ROBERT J KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1921

17

I HEREBY CERTIFY, That I attended deceased from March, 1921, to June 13th, 1921, that I last saw h~~er~~ alive on June 13th, 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

General metastasis (following removal of breast for Carcinoma about 1 yr. ago) with special involvement of brain & end =

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 1 yr. Date of (about)

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm F. Lockwood M.D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 16 1921

20 UNDERTAKER: Henry Watkins Son Co

ADDRESS: Cathedral & Mt Royal Ave

~~Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.~~

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54557

CERTIFICATE OF DEATH.

28V D 54557

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 532 no Hoffman ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Garfield McIntyre

(a) RESIDENCE. NO. 532 W Hoffman St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE)~~ of Minnie McIntyre

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Not given

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not given

14 Informant Minnie McIntyre

(Address) 532 W Hoffman

15 Filed JUN 15 1921 ROBERT B. ADAMS Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1921, to June 15, 1921, that I last saw h-im alive on June 14, 19 21, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Ac Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum test

(Signed) Edw Short M. D.

6/15 1921 (Address) 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	June 16 1921
20 UNDERTAKER	ADDRESS
David Easton	Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54558

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 572 Walnut Ave. St.; 17 WARD)

2-FULL NAME Annie Burk

(a) RESIDENCE. NO. 572 Walnut Ave St.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno. Burk

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant David Eaton

(Address) 916 Eutaw

15 Filed JUN 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 4, 1921, to June 12, 1921.

that I last saw her alive on June 12, 1921.

and that death occurred, on the date stated above, at 5 45 p.m.

The CAUSE OF DEATH* was as follows:

a Pulmonary Tuberculosis

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Frank E. Wynn M. D.

, 19 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 15, 1921
20 UNDERTAKER David Eaton	ADDRESS 916 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54559

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-91 D 54559

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 18 WARD)

2-FULL NAME Annie M. Washington

(a) RESIDENCE. NO. 918 N. Pierce ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Washington

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bay View Hospital Balto. Md.

15 Filed JUN 15 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1921, to June 13, 1921, that I last saw her alive on June 13, 1921, and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Terminal/ Broncho-Pneumonia

CONTRIBUTORY (Secondary) Myocarditis (duration) ... yrs. ... mos. ... ds.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) N. Goldsmith, M. D.

6/14/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 17 1921
20 UNDERTAKER	ADDRESS 916
David Corbin	Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Dames

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54560

64 v D 54560

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3122 Monticello ave ST.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Dames

(Residence in Baltimore: No. 3122 monticello av St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 24 (Month) 1858 (Day) 1 (Year)

7-AGE, 72 yrs. 11 mos. 21 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home wife
(b) General nature of Industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Co md

PARENTS.

10-NAME OF FATHER, Benjamin Wilmington

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Emma McGary

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Dames Husband

(Address) 3122 Monticello ave

15-

Filed JUN 15 1921 ROBERT B BRAUER Registrar.

Burial Permit 9144

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14 (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 12 1921, to June 14 1921, that I saw her alive on June 13 1921, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia Crouposlobar

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) H. Young Whittaker M. D.

June 14 1921 (Address) 1 E. Lafayette ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Dames

DATE OF BURIAL, June 17, 1921

20-UNDERTAKER C. H. Weidefeld

ADDRESS 501 E Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54561

CERTIFICATE OF DEATH.

90 D 54561

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3103 Montebello ave ST.) 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry W. Leonard.

(Residence in Baltimore: No. 3103 Montebello ave. St.; 71 yrs., mos. da.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH. Nov 15, 1856. (Month) (Day) (Year)

7-AGE. 65 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Machinist
(b) General nature of industry, business, or establishment in which employed (or employer). 031

9-BIRTHPLACE. (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Daniel Leonard.

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary Jones

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Leonard.

(Address) 3103 Montebello Ave.

15- Filed. JUN 15 1921 191.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 13, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 13 1921, that I saw him alive on June 11 1921, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis, with Emphysema. Gradual wasting of tissues.

(Duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) E. H. Duncan M. D.

June 13, 1921 (Address) 5106 York Road.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park.

DATE OF BURIAL. June 15, 1921.

20-UNDERTAKER C. A. Windsor Jr.

ADDRESS 501 E 22d St

Rev. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54562

CERTIFICATE OF DEATH.

X 80 D 54562

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Judge Wm. Alexander Blount.

(a) RESIDENCE. No. Pensacola, Fla. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Fernando Blount Olson

6 DATE OF BIRTH (month, day, and year) Oct 25, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	7	21.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer. 042

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ala.

PARENTS

10 NAME OF FATHER Alexander C. Blount

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER ? Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Miss.

14 Informant (Address) Johns Hopkins Hospital Records.

15 Filed JUN 15 1921 ROBERT I. EMBLER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 14. 1921. to June 15. 1921. that I last saw him alive on June 15. 1921. and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. [illegible] M. D.

6-15-21, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pensacola Fla

DATE OF BURIAL: June 15 1921

20 UNDERTAKER: John O. Mitchell

ADDRESS: 120 W Zaragoza

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54563

CERTIFICATE OF DEATH.

79 D 54563

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1842 W. Fayette St. ST.: 20 WARD)

2-FULL NAME Bridget Fahey.

(a) RESIDENCE. NO. 1842 W. Fayette St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1.1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Michael Fahey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs. L. Echle 1842 W. Fayette St.

15 Filed JUN 15 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14th 19

17 I HEREBY CERTIFY, That I attended deceased from January 10 21 to June 14, 19, that I last saw her alive on June 13, 1921. 19, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Myocarditis (Chronic)

5
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Edward O. Goodalmer M. D.
3/15/24 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: 6/17/21 19

20 UNDERTAKER: Jno. A. Farley ADDRESS: Fulton & Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54564

92 D 54564

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Poplar Grove ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Bernardine Keelty

(a) RESIDENCE. NO. 1123 Poplar Grove St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baito

PARENTS

10 NAME OF FATHER James Keelty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Sheridan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Nora Keelty
(Address) 1123 Poplar Grove St.

15 Filed JUN 15 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1921, to June 14, 19.., that I last saw her alive on June 14, 19.., and that death occurred, on the date stated above, at 10.10 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Odema of Lungs 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) Edgar Vanculen, M. D.

6/15, 19.. (Address) 224 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	6/16/21 19
20 UNDERTAKER	ADDRESS
Geo. A. Farley	Fulton & Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54565

CERTIFICATE OF DEATH.

6 127

D 54565

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Women's Hosp. St.; 6 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Goldstein

(Residence in Baltimore: No. 123 N. Broadway St.; yrs., mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH. June 6, 1921 (Month) (Day) (Year)

7-AGE. ....yrs. ....mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Infant

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. H. Henry Goldstein

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Lillian Hendler

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. L. H. Hendler

(Address) 1710 Eutaw Place

15- FILED JUN 15 1921 ROBERT I. KRAUTER Registrar. (D.) Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 15, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Circumcision (Ritual) 12 hrs.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 12 ds.

(Signed) J. J. T. Hennessy M. D. (Coroner)

June 15, 1921 (Address) 2812 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 9 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Women's Hosp.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Fairview DATE OF BURIAL. June 15 1921

20-UNDERTAKER Geo. Lewis ADDRESS 141 E. Lee

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Rabbi. Very shortly after he developed convulsions, seizures, cyanosis & coma. He remained this way until the day of his death. No reason can be ascertained.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urænia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54566

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 54566

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1532 E. Madison ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F Warfield

(a) RESIDENCE. NO. 1532 E. Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William G. Warfield

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	"		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Tipsy Johnson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Lloyd

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant William G. Warfield

(Address) 1532 Madison St

15 Filed JUN 15 1921 ROBERT J KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13-1921

17 I HEREBY CERTIFY, That I attended deceased from 5-16-1921, to 6-13-1921, that I last saw h~~er~~ alive on 6-13-1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. H. Cargill, M. D.

6-14-1921 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	June 16 1921
20 UNDERTAKER	ADDRESS
C. H. Bailey	1421 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54567 D 54567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Hanbert ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Konkoska

(a) RESIDENCE. NO. 1125 Hanbert ST., 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ood

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Kunkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Sikorska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Kunkowski (Address) 1269 Carrie St

15 Filed JUN 15 1921 19 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 14 - 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-6-, 1921, to 6-14-, 1921, that I last saw h[illegible] alive on 6-13-, 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH was as follows:

Diarrhea and enteritis

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Artificial feeding

(duration) ... yrs. ... mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none needed

(Signed) Lyman Proctor, M. D.

6-14, 1921 (Address) 1202 N North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 16 1921

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54568 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54568

CERTIFICATE OF DEATH.

REGISTERED NO. C 19

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 416 N Durham St.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas W Chase

(Residence in Baltimore: No. 416 N Durham St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country), born in Balt-City

PARENTS.

10-NAME OF FATHER, John Chase

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Laura Delia

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Chase

(Address) 416 N Durham

15- Filed JUN 15 1921, 191.....

Robert P. Harrison,
Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis
Exhaustion
(Duration) yr. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) C E Slade M. D.
(Coroner.)
June 13/21 (Address) 143 N. Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Funeral Cemetery — DATE OF BURIAL, June 16, 1921

20-UNDERTAKER Inra Robert A Elliott — ADDRESS 1720 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54569

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54569

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 69

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gross

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospitals

15 Filed JUN 15 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1920 to June 13, 1921, that I last saw him alive on June 12, 1921, and that death occurred, on the date stated above, at 6:20 A m.

The CAUSE OF DEATH* was as follows:

Epilepsy.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) J Ottenman, M. D.

6/13/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 16 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Lakeland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE must be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

D 54570

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 54570

CERTIFICATE OF DEATH

92-010

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 2223 Hargrove alley St. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Wm H. Blackstone

(Residence in Baltimore: No. 2223 Hargrove alley St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: ..... (Month) ..... (Day) ....., 1 (Year)

7 AGE: 47 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

9 BIRTHPLACE (State or country): born in Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Blackston Wife

(Address) 2223 Hargrove Alley

15 Robert P. Harrison,

Filed ..... 191 ..... REGISTRAR

Burial Permit Clerk

JUN 15 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 14 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1920 to date 1921.

that I saw h[illegible] alive on June 11, 1921,

and that death occurred, on the date stated above, at 7,40 P m.

The CAUSE OF DEATH* was as follows: Over

Gas, Followed with Pneumonia

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY) Acute Indigestion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Gabriel M. D.

June 4, 1921 (Address) 2413 E Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: June 15, 1921

20 UNDERTAKER: Mrs R A Elliott

ADDRESS 1727 Ashlandale

GE should be stated EXACTLY. PHYSICIANS should
properly classified. Exact statement of OCCUPATION
item of information should be carefully supplied. AGE s
state CAUSE OF DEATH in plain terms, so that it may be prop
is very important. See instructions on back of certificate.

D 54571 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54571

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 105 S Ann St. WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Pabst Schneider

(Residence in Baltimore: No. 105 S Ann St. St.: 44 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. Oct 16, 1875
(Month) (Day) (Year)

7-AGE. 45 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Michael Zyman

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Emma Pickarski

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Pabst

(Address) 105 S Ann St

15-

Robert F. Harrison,

Filed ....., 191.... Registrar.

JUN 5 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

....(Duration)....yrs....mos....ds.

(Signed) [illegible] M. D.
(Coroner)

6/15, 1921. (Address) 1824 E Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, June 17, 1921.

20-UNDERTAKER M. J. Sadowski ADDRESS 705 S. Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54572 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ D 54572

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Municipal Tuberculosis Hospital St. 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Baugher

(a) RESIDENCE. No. 332 N. Gay st. St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER James Baugher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Mary Collier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant Hospital Records (Address) M.I.T.H.

15 Filed JUN 15 1921, 19... Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 8, 1921, to June 11, 1921, that I last saw him alive on June 10, 1921, and that death occurred, on the date stated above, at 4.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) [signature] M. D.

6-11-21, 19... (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19...

20 UNDERTAKER Commissioner Health,

ADDRESS JUN 15 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54573

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54573

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Thomas

(a) RESIDENCE. No. 806 Rutland Ave. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: W Thomas

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Robert Wallis

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Bettie Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Mary Thomas

(Address): 806 Rutland Ave

15 Filed . 19 . Registrar

No. 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 14 - 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-1-, 1921, to 6-14-, 1921, that I last saw Mr alive on 6-14-, 1921, and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Final

(duration) yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Abdominal Cancer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Barnett, M. D.

6-14, 1924 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: JUN 15 1924

20 UNDERTAKER: Robert F. Barnhard

ADDRESS: Baltimore

Commissioner Health,

Burial Permit Clerk.

UNIVERSITY OF MARYLAND

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54574

D 54574

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 Colvin St ST.; 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Handmaker

(a) RESIDENCE. No. 435 Colvin St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ——— 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 E Baltimore St

15 Filed JUN 15 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15 1921

17

I HEREBY CERTIFY, That I attended deceased from June 14, 1921, to June 15, 1921, that I last saw h[illegible] alive on June 14, 1921, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension B.P. Syst. 240

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage 13 hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Blood Pressure, Paralysis

(Signed) Frank R. Smith, M. D.

6/15 1921 (Address) 927 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	6/16 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause stated EXACTLY. PHYSICIANS should be very careful to enter items of information required. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

D 54575 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54575

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1326 n Broduay ST.. 8 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Phillip J. Byrd.

(Residence in Baltimore: No. 1326 n Bdway. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Wht	Bach.

6-DATE OF BIRTH, June (Month) 14 (Day), 194 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 20 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Philip J. Byrd.

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Louisa J. Bowman

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Philip J. Bowman

(Address) 1326 N. Broadway

15- Robert F. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

JUN 15 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematue Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. F. Kelley (Coroner.) M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cemy	June 16 1921
20-UNDERTAKER	**ADDRESS**
Henry Hoech Son	1301 E Fay-ette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54576

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54576

CERTIFICATE OF DEATH.

X 53

REGISTERED NO.

1-PLACE OF DEATH Howard Kelly Hosp.

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie L. Bullock.

(a) RESIDENCE. No. 1418 Eutaw Place ST., WARD. Montgomery Ala.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Bullock

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Shorter Alabama

PARENTS

10 NAME OF FATHER John Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Eva Pinkston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant (Address) James A. Bullock Montgomery Ala

15 Filed ... 19... Robert P. Harrison, Registrar

NOV 15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 22 1921, to June 15 1921, that I last saw h.. alive on June 15 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Hodgkin's disease

(duration) 5 to 6 months yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? O Date of

Was there an autopsy? O

What test confirmed diagnosis?

(Signed) Dudley A. Tobuen M. D.

, 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Montgomery Ala	June 14 1921
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W Worthave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 54577

D 54577

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54577

120-091

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.) 19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Meredith

(a) RESIDENCE. No. 306 South Fulton Ave. (St.) Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Meredith Same address

6 DATE OF BIRTH (month, day, and year) July 25th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer Fredk Co.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John T. Meredith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredk Co. Maryland

12 MAIDEN NAME OF MOTHER Margaret Mercier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fredk Co Maryland

14 Informant (Address) J. H. H Records

15 Filed JUN 15 1921, 19 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-14 1921

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1921, to June 6, 1921, that I last saw him alive on June 6, 1921, and that death occurred, on the date stated above, at 5.40 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic nephritis, tuberculosis (?) arteriosclerosis ? (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis? — Microscopic 307

(Signed) V. K. Mason, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Perry Hall M. E. Cemetery	June 17 1921

20 UNDERTAKER	ADDRESS
Fredk Lazarus Sons	Fullerton Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54578

HEALTH DEPARTMENT—CITY OF BALTIMORE

H5

D 54578

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 N. Monroe ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Diefenbach

(a) RESIDENCE. No. 229 N. Monroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Diefenbach

6 DATE OF BIRTH (month, day, and year) Oct 24-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John J Diefenbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John J Diefenbach (Address) 1800 W Penrose Ave

15 Filed JUN 15 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15-1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 14-1921, to June 14-1921, that I last saw him alive on June 14-1921, and that death occurred, on the date stated above, at 1205 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) X yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) C Ker Williams, M. D.

, 19 (Address) 601 Carroll Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park — DATE OF BURIAL June 17 1921

20 UNDERTAKER Wm J Ticknor Sons — ADDRESS N Y Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54579 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54579

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH Home REGISTERED NO.

CITY OF BALTIMORE: (No. 727 W. Saratoga ST.; 4th WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Cammarata

(a) RESIDENCE. No. 727 W. Saratoga ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stella Cammarata

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57				

8 OCCUPATION OF DECEASED 070

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Lexington Mkt

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Sicily Italy

PARENTS

10 NAME OF FATHER Thomas Cammarata

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sicily Italy

12 MAIDEN NAME OF MOTHER Carmela Fata

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sicily Italy

14 Informant Mrs. M. Costello
(Address) 727 W. Saratoga

15 Filed JUN 15 1921, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-1-, 1921, to 6-15-, 1921, that I last saw him alive on 6-15, 1921, and that death occurred, on the date stated above, at 7.10 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.
Chronic diffuse Nephritis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompen
Uremia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Symp.

(Signed) J. J. Swan M. D.

. 19 (Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL June 17 1921

20 UNDERTAKER N. J. Tickner & Sons ADDRESS N. Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54580

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 54580

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1257 William St ST.: 24 WARD)

2-FULL NAME Margaret E Cooper

(a) RESIDENCE. No. 1257 William St ST., 24 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — — 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Christener Merryman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Saml. Cooper
(Address) 1257 William St

15 Filed JUN 15 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10 1921, to June 13 1921, that I last saw h alive on June 13 1921, and that death occurred, on the date stated above, at 6 30 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Paralysis (Apoplectic) one year

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at this place

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Henry B Kolb, M. D.

June 15 1921 (Address) 1203 Light St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BU
Baltimore Cemetery	6/16/21

20 UNDERTAKER Jno. J. Lakey & Sons ADDRESS 31 N Eu

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Army)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54581

D 54581

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3017 Hutson ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert H. Harvey

(a) RESIDENCE. NO. 3017 Hutson ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Harvey

6 DATE OF BIRTH (month, day, and year) June 25 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dorit Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Robert Harvey Jr
(Address) 3017 Hutson

15 Filed JUN 15 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Did Not attend, 19 , to , 19 .

that I last saw h alive on , 19 .

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Health officer P. L. Long, M. D.

6-15. 1921 (Address) 2709 Eastern av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	June 16 1921
20 UNDERTAKER	ADDRESS
Wendell Bryfogle & Son	378 N

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54582

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

29 D 54582

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 3700 Fairview Av ST.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Ferris

(Residence in Baltimore: No. 3700 Fairview Av St.; 50 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: March (Month) 3 (Day) 1845 (Year)

7-AGE: 76 yrs. 3 mos. 12 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): (0)

9-BIRTHPLACE (State or country): Washington D.C.

PARENTS

10-NAME OF FATHER: William C. Simons

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Virginia R. Myers

13-BIRTHPLACE OF MOTHER (State or country): Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs T. S. Dowling

(Address) 2013 Edmondson Ave

15- Filed JUN 16 1921 ..... 191 ..... BOTEN & KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June (Month) 15th (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 13, 1921, to, June 15th 1921, that I saw h[illegible] alive on June 15th 1921, and that death occurred, on the date stated above, at 4.15 A m. The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 10 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Cardiac Insufficiency

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed), Herbert E. Tapp M. D.

June 15th 1921. [Address] 3050 N. Monastery Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Woodlawn County — DATE OF BURIAL: June 17th 1921

20-UNDERTAKER: Graham F. Walker — ADDRESS: 723 W. Lafayette Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54583c C

CERTIFICATE OF DEATH.

54583

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: V WARD)

2-FULL NAME Anthonio Leitner

(a) RESIDENCE. NO. 416 S. Washington St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced WIFE or ~~HUSBAND~~ of Mrs Lizzie Leitner same address

6 DATE OF BIRTH (month, day, and year) April 23 - 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Anton Leitner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) J. H. H. Records.

15 Filed JUN 16 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4 - 1921, to June 16, 1921, that I last saw him alive on June 16, 1921, and that death occurred, on the date stated above, at 4 55 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Auricular fibrillation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (? Lobar) 5

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. R. Mason, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	June 16/21 19

20 UNDERTAKER Wm Cook ADDRESS 502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Homewood 25 — Blocher

D 54584

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

150 N D 54584

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2327 Guilford Ave) (WARD) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick A. Blocher Jr

(Residence in Baltimore: No. 2327 Guilford Ave) S. Lafs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: June (Month) 8 (Day), 1921 (Year)

7-AGE: ..... yrs. ..... mos. 7 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Frederick A. Blocher Sr

11-BIRTHPLACE OF FATHER (State or country): Florida

12-MAIDEN NAME OF MOTHER: Mary Roth

13-BIRTHPLACE OF MOTHER (State or country): Brooklyn New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick A. Blocher

(Address) 2327 Guilford Ave

15- JUN 16 1921 ROBERT J. KRAUTER

Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June (Month) 15 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8, 1921, to, June 15 1921, that I saw h~~im~~ alive on June 14 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis

(Duration) ..... yrs ..... mos. ..... ds.

Contributory (SECONDARY) Encephalo-meningitis

(Duration) ..... yrs ..... mos. 6 ds.

(Signed), E. L. Bouchelle M. D.

6/15 1921 [Address] 2104 St Paul St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery DATE OF BURIAL: June 16, 1921

20-UNDERTAKER: William Cook ADDRESS: 502 E North Ave

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54585

CERTIFICATE OF DEATH.

91 ✓ D 54585

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Abramowitz

(Residence in Baltimore: No. 134 N. Exeter St.; St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russian

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1141 E. Baltimore St.

15- Filed JUN 16 1921, 191.... ROBERT J. KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 15th. (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14th 1921. P.M. 191..., to June 15th 1921 191 7:30 P.M. that I saw him alive on June 15th. 1921, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

.....

.....

..... (Duration).....yrs.....mos. 4 .....ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

..... (Duration).....yrs.....mos. 1 .....ds.

(Signed) J. F. Dinkins M. D.

June 15, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 134 N. Exeter St.

19-PLACE OF BURIAL OR REMOVAL, Filbert Street Cem. DATE OF BURIAL, June 17th., 1921

20-UNDERTAKER Jack Lewis ADDRESS 1141 E. Balto

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54586

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54586

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2048 Fountain ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Frank Nizolek

(a) RESIDENCE. NO. 2048 Fountain ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/8/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4/6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Louis Nizoli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Marie Dzyechenitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Louis Nizoli

(Address) 2048 Fountain St.

15 Filed JUN 16 1921 ROBERT J. KRAUTER Registrar

Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to June 15, 1921, that I last saw him alive on June 15, 1921, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 10 hrs.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lowe J. Stringer M. D.

June 15, 1921 (Address) 2002 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	June 16 1921

20 UNDERTAKER William Falkowski ADDRESS 1618 Eastern

TION is very important. See instructions on back of certificates.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54587

CERTIFICATE OF DEATH.

105 D 54587

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Lemmon St ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wm. H. Copp.

(a) RESIDENCE. NO. 906 Lemmon St ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 23-1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	9	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Copp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lula E. Baston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant John Copp.
(Address) 906 Lemmon St

15 Filed JUN 16 1921 Burial ... Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1921

17 I HEREBY CERTIFY, That I attended deceased from May 29th, 1921, to June 14, 1921, that I last saw h.. alive on June 14, 1921, and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J. Murray, M. D.

6-15, 1921 (Address) 516 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 17 1921
20 UNDERTAKER Geo. J. Smith	ADDRESS 1000 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 54588

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3114 E Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernhardine Blenkner

(a) RESIDENCE. NO. 3114 E Monument ST., C WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Peter Blenkner

6 DATE OF BIRTH (month, day, and year) Nov 23-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at home ppb
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS
10 NAME OF FATHER — Bauer
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Dont Know
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chris Blenkner
(Address) 3114 E Monument

15 JUN 16 1921

ROBERT J KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 17 — 1921, to June 13 — 1921.
that I last saw h alive on June 13 1921.
and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Hepatic - Malignant Dis -

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General Health

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Local
(Signed) [illegible], M. D.
14/6/1921 (Address) 125 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery.	June 16 1921
20 UNDERTAKER	ADDRESS
J. Kenny & Co	2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

6-091

D 54589

CERTIFICATE OF DEATH.

D 54589

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 10 W. Lee St. (Ward) 22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Francis Hurley

(a) RESIDENCE. No. 10 W. Lee St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June, 24, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Francis W. Hurley

11 BIRTHPLACE OF FATHER (city or town) Boston
(State or country) Massachusetts.

12 MAIDEN NAME OF MOTHER Lista Hurley

13 BIRTHPLACE OF MOTHER (city or town) Nova Scotia
(State or country) Canada

14 Informant Francis W. Hurley
(Address) 10 W Lee St.

15 Filed JUN 16 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 13, 1921, to June, 15, 1921, that I last saw him alive on June, 14, 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Measles (3 wks ago)

Chicken Pox (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no.

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dana Franklin, M. D.

6/15, 1921 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK.

DATE OF BURIAL: JUN 16 1921

20 UNDERTAKER: JOHN F. DENNY

ADDRESS: 715 LIGHT ST

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54590

CERTIFICATE OF DEATH.

6-09 D 54590

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 S. Bond St.; W Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Helowicz

(a) RESIDENCE. No. 839 S. Bond St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. 8 mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. 100 Clerk

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 16 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael Helowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Wlodarzyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michael Helowicz. (Address) #839 S. Bond St.

15 Filed JUN 16 1921 ROBERT J. BRADLEY Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10th, 1921, to June 14th, 1921, that I last saw h[e] alive on June 14th, 1921, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Bronchs — Pneumonia

DW

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. F. Reis, M. D.

June 15 1921 (Address) 24 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL June 16th 1921.

20 UNDERTAKER M. F. Sadowski, ADDRESS 705 S Ann

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

History of having had measles 2 wks. prior to pneumonia

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 D 54591

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1085 W Fayette St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Brocato

(a) RESIDENCE. No. 1085 W Fayette St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER S. Brocato

11 BIRTHPLACE OF FATHER (city or town) Cefalu
(State or country) Italy

12 MAIDEN NAME OF MOTHER M. Puma

13 BIRTHPLACE OF MOTHER (city or town) Cefalu
(State or country) Italy

14 Informant S. Brocato
(Address) 1085 W Fayette St.

15 JUN 16 1921 ROBERT J. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-14, 1921, to 6-15, 1921, that I last saw him alive on 6-15, 1921, and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Fracture of Tibia - Open 2 mo. ago - Pressure sore - Gas gangrene of leg - 1 (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tetanus - (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) S. D. Swaim, M. D.

6-15, 1921 (Address) 1601 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: June 17 1921

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W Fayette

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54592

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

175 D 54592

REGISTERED No. C

CITY OF BALTIMORE (No. South Baltimore General Hospital ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clyde H. Pitt.

(Residence in Baltimore: No. 2504 Frederick Ave. St.: yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, January 28th. 1893, 1
(Month) (Day) (Year)

7-AGE, 28 yrs. 4 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brakeman. 073
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. Co.

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Walter Pitt.

11-BIRTHPLACE OF FATHER (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Pitt. (wife)

(Address) 2504 Frederick Ave.

15- JUN 16 1921 Filed ....., 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14th. 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally run over and mangled about the legs and arms by cars of the B. & O. R. R. Co.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Lloyd Lemmard M. D.
(Coroner.)

June 15, 1921 (Address) 1217 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? B. & O. R. R. tracks foot of Webster St.

Former or usual residence June 15, 1921, 8 p. m.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	June 16 1921
20-UNDERTAKER	ADDRESS
W. J. Lee	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. F. Co. 1000 Bks.

14882 6 D 54593

HEALTH DEPARTMENT—CITY OF BALTIMORE

14 ✓ D 54593

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Shannon.

(a) RESIDENCE. No. 1316 E. Monument St ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (PARENTS) Adville + Sarah Shannon

6 DATE OF BIRTH (month, day, and year) Sept 24, 1918.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 880

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adville Shannon.

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Sarah Henson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital. Relative

15 Filed JUN 16 1921 ROBERT I KRAUTLE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1921, to June 15, 1921, that I last saw h[illegible] alive on June 15, 1921, and that death occurred, on the date stated above, at 5-20 A m.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner).

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Culture.

(Signed) Horton Casparis, M. D.

6-15-21 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	June 17 1921
20 UNDERTAKER	ADDRESS
R C Groth	1405 McElderry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54594

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54594

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Lawler-

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	69	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer) Charity work.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Lawler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kenney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 JUN 16 1921 ROBERT I. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-15-1921

17 I HEREBY CERTIFY, That I attended deceased from June 1903, 19.., to June 15-21, 1921, that I last saw h alive on June 13, 1921, and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:

Chr Nephritis - Complicated by Cerebral Hemorrhage

(duration) 0 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr. Mania -

(duration) 26 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Florence S. C

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

June 15, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL June 16 1921.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54595

CERTIFICATE OF DEATH.

91 D 54595

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Light St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte M. Hamden

(a) RESIDENCE. No. 1512 Williams ST. I WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 1 1920

7 AGE: Years — Months: 10 — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Frank L. Hamden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Grace D. Nick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Charles Hamden

(Address): 1512 Williams St.

15 Filed JUN 16 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14- 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1921, to June 14- 1921, that I last saw h alive on June 13- 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Empyaemia

(duration 2 mos. 15 ds.)

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) — yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? 1512 Williams

Did an operation precede death? yes Date of May 31/21

Was there an autopsy? yes

What test confirmed diagnosis? Pleural Puncture

(Signed) [illegible] M. D.

, 19 (Address) 1240 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: 6/16/ 19 21

20 UNDERTAKER: Margaret E. Flynn — ADDRESS: 1422 Mt

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54596

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 So Port ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Wostpiak

(a) RESIDENCE. NO. 622 So Port St. ST. 1 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Ten mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter Wojciak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Sophia Borsicka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Walter Wojtyzka 622 S. Port

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 19 1

17 I HEREBY CERTIFY, That I attended deceased from June 16, 19 1, to June 16, 19 1

that I last saw h[illegible] alive on June 16, 19 1,

and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Transverse Colon -
Difficult Delivery -
Suffocation
Died Shortly

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Faulty Practices

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Joseph L. Valentini M. D.

19 1 (Address) 2 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: 6/16 19

20 UNDERTAKER: [illegible] Fieldcrest 4658

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WN 161921

Spec.—8-24-14—M. & T.—2000 Bks.

D 54597

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54597

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Hornstein

(Residence in Baltimore: No. 2227 Linden ave St.; ...yrs.. ...mos. ...ds.)

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 15 (Day), 1921 (Year)

7-AGE, ...yrs. ...mos. ...ds. If LESS than 1 day, 2 hrs. or 40 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None DD
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Benjamin S Hornstein

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Ida Fredstein

13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norman E. Tannenbaum

(Address) Womans Hospital.

15-

Filed ..., 191...

Robert P. Harrison,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1921, to June 191..., that I saw him alive on June 15 1921, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Prematurity — 5½ months

(Duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary) Premature labor —

(Duration) ...yrs. ...mos. ...da.

(Signed) Norman E. Tannenbaum M. D.

June ..., 191... (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. 2 hrs 40 m ...mos. ...da. In the State ...yrs. ...mos. ...da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Hebrew Sterling Run	6/16..., 1921

20-UNDERTAKER Jack Levin ADDRESS 1411 E Balto St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

176745 D 54598

HEALTH DEPARTMENT—CITY OF BALTIMORE D 54598

CERTIFICATE OF DEATH.

127

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (ST.) 16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Gibbons. Balto Md.

(a) RESIDENCE. NO. 904 Edmondson Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced (or) WIFE of: HUSBAND of Mrs A. B. Everett 1737 E Oliver St (Trune)

6 DATE OF BIRTH (month, day, and year): 1853.

7 AGE: Years 68. Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Handy Man. 986

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Burton Gibbons.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Betsy Parsons.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Johns Hopkins Hospital. Records Robert P. Harrison,

15 Filed . 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14. 1921

17 I HEREBY CERTIFY, That I attended deceased from March 8. 1921. to June 14. 1921. that I last saw him alive on June 14 1921. and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Anaemia

Pyelonephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pyelo-nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 5-31-21

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood exa.

(Signed) H A Bailey. M. D.

6-15. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
SOMERSET CO PRINCESS ANNE Md	JUNE 18 1921
20 UNDERTAKER	ADDRESS CALDEN HOLLINS
Robert Brockson	

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 54599

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

D 54599

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby of Abraham & Annie Socks

(a) RESIDENCE NO. 846 N. Eutaw St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 16 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	—	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Abraham Socks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Herstock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant ... Jack Laurs
(Address) 1411 E Balto St

15 Filed ..., 19 ... Registrar

Robert P. Harrison,
Burial Permit Clerk.

6 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to June 16, 1921, that I last saw him alive on June 15, 1921, and that death occurred, on the date stated above, at 4 A, m.

The CAUSE OF DEATH* was as follows: Premature birth and result of malformation in utero

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Heat radiation & auto intoxication (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. P. Muse, M. D.

6/16, 1921 (Address) 1037 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state 1) Means and Nature of Injury, and 2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nelson Mus Lood	6/16 1921
20 UNDERTAKER	ADDRESS
Jack Laurs	1411 E Balto

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- be properly classified. ...ald state ... plain terms, so that it may

Spec.—82414—M. & T.—3000 Bks.

D 54600 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 54600

CERTIFICATE OF DEATH. 105

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 632 Gold St.) 15 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie Kay Cole

(Residence in Baltimore: No. 632 Gold St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1876 (Year)

7-AGE 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lunch Room Proprietress
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Richmond Co Va

PARENTS.

10-NAME OF FATHER, Peter Powers

11-BIRTHPLACE OF FATHER (State or Country), Richmond Co Va

12-MAIDEN NAME OF MOTHER Dimithy Ann Bryant

13-BIRTHPLACE OF MOTHER (State or Country), Richmond Co. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William A Cole (Husband)
(Address) 632 Gold St

15-
Filed ....., Robert P. Harrison Registrar.

JUN 16 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Baltimore June 15, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 8 1921, to June 14 1921, that I saw h..... alive on June 14 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Gastro Enteritis
.....
..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. E. Daugherty M. D.
June 15, 1921 (Address) 1602 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Richmond Va C. DATE OF BURIAL, June 17 1921

20-UNDERTAKER James H Dems ADDRESS 1303 Pennsylvania Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54601

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105

D 54601

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 Baker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elijah Randall

(a) RESIDENCE. No. 620 Baker ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband.

6 DATE OF BIRTH (month, day, and year): June 1868

7 AGE: Years 53; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: Elijah Randall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Lula Randall (Address): 620 Baker St.

15 Filed: Robert P. Harrison, Registrar
Burial Permit Clerk.

N 16 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/15- 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/28, 1921, to 6/15-, 1921,

that I last saw h[illegible] alive on 6/15-, 1921,

and that death occurred, on the date stated above, at 1 [illegible] m.

The CAUSE OF DEATH* was as follows: Acute Gastro enteritis with Gastric ulcer & Gun shot wound.

OVER

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Sig[illegible] Buckler, M. D.

, 19 (Address) 2134 Dill. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — JUN 1 — DATE OF BURIAL: 1921

20 UNDERTAKER: James H Dennis — ADDRESS 1303 Pressing 18

IMPORTANT: Name of deceased must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nonmalignant. Probably Perforating Duodenal ulcer.

Spec—6-9-19—H. P. Co.—1000 Bks.

D 54602 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54602

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1846 W. North Ave. ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda A. Anstine

(a) RESIDENCE. No. 1846 W. North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm N. Anstine

6 DATE OF BIRTH (month, day, and year) Feby 24, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Clara Ryan
(Address) 1828 Harlem ave

15 Filed 6 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to June 16/21, that I last saw h[illegible] alive on June 15/21, and that death occurred, on the date stated above, at 4 05 A m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Nephritis.

(duration) 6 ds.

(b) Pachion Co Pneumonia

CONTRIBUTORY (Secondary) Scarlet Fever (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr E Stanton, M. D.

, 19 (Address) 1929 W Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	June 18 1921

20 UNDERTAKER Harry W. Eckel ADDRESS 1924 W Baltimore

THIS is very important. See instructions on back of certificates. So that it may be properly classified. Exact statement of OCCUPATION should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54603

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54603

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 N. Luzerne St. 30 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Foylor

(a) RESIDENCE. No. 13 N. Smallwood St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~DAUGHTER OF~~ WIFE of Levin Foylor (dec.)

6 DATE OF BIRTH (month, day, and year) Nov. 8. 1851?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (own) Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Reitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Raline?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Mrs. George (Address) 1320 N. Luzerne st

15 Filed 19 Robert P. Harrison, Registrar

161921 Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14. 19 21

17 I HEREBY CERTIFY, That I attended deceased from April 15 19 21, to June 14 19 21, that I last saw h[illegible] alive on June 14 19 21, and that death occurred, on the date stated above, at 11.20 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoidem

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) 1 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. J. Marx M. D.

June 19 21 (Address) 827 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 17 19 21

20 UNDERTAKER Henry Lutz ADDRESS 1007 N. Bond

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54604

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54604

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 82 Darby St. ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma M. Valentine.

(a) RESIDENCE. NO. 82 Darby Street ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Raymond H. Valentine

6 DATE OF BIRTH (month, day, and year) March 19 - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Louise Lamp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Raymond H. Valentine 82 Darby St.

15 Filed Robert P. Harrison, Registrar

JUN 6 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to June 15, 1921, that I last saw her alive on June 14, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 15 days ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) R. H. Richardson, M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	June 17 1921
20 UNDERTAKER	ADDRESS
Horace F. Burger	3631 Falls Rd.

THIS is very important. See instructions on back of certificates. Be sure that it may be properly classified. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54605 ×55 1.01 D 54605

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Wettenkamp

(Residence in Baltimore: No. Johns Hopkins Hospital St.; Johns yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1865
(Month) (Day) (Year)

7-AGE, 56 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Weetenkamp

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records

(Address) .....

15- JUN 17 1921 Filed ....., 191.... ROBERT I KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...June 17, ..., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to June 17, 1921, that I saw him alive on June 16, 1921, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows: Encephalitis OVER

..... (Duration) ....yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) R. Femoral Thrombosis (Duration) ....yrs. ....mos. 10 hrs. ds.

(Signed) D. O'Brien M. D.

June 17..., 1921 (Address) Johns Hopkins Hospital.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 10 hrs. In the State 50 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Marriottsville, Md.

Former or usual residence Marriottsville, Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sykesville Md	June 19 1921

20-UNDERTAKER Jas. P. Kerr ADDRESS Sykesville

...directions on back of certificate. Exact statement of OCCUPATION is very

Remarks of 104° F and a thrombosis involving one of the deep veins of the Right thigh. Epidemic encephalitis

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Daisie M. Brimmer

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54606 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54606

CERTIFICATE OF DEATH. 43

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2127 Wachbrook Av. ST.; 27 WARD)

2-FULL NAME Mrs Daisie M. Brimmer

(a) RESIDENCE. No. 632 Portland ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred life 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wht.	Married

5a If married, widowed, or divorced (or) WIFE of Harry H. Brimmer

6 DATE OF BIRTH (month, day, and year) June 26th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	11	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) — 037
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Talbott Co. Md.

PARENTS

10 NAME OF FATHER Wm P. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbott Co.

12 MAIDEN NAME OF MOTHER Sarah Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant (Address) Mrs Blanche T. Escaville 2127 Wachbrook Av

15 Filed JUN 17 1921 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6 1921, to June 15 1921, that I last saw her alive on June 14 1921, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:
Recurrent Cancer of left breast, with pressure on Veins of neck & Chest.
about 2 (duration) yrs. mos. ds.,

CONTRIBUTORY (Secondary) Gradual Weakening, Wasting (duration) yrs. one mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept. 1919

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) E. L. Brack, M. D.

6/15, 1921 (Address) 1605 N. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	June 17th 1921
20 UNDERTAKER	ADDRESS
The Mrs. John W. Siegel & Son,	801 W. Fayette St

HON is very important. See instructions on back of certificates. be properly classified. Exact statement of OCCUPA- ...ame state ...it may be pre-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54607

D 54607

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1514 (St.) N. Spring (Ward) 8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Mae Reed

(a) RESIDENCE. No. 1514 N. Spring St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed or divorced HUSBAND of (or) WIFE of: ——

6 DATE OF BIRTH (month, day, and year): July 22 1913

7 AGE — Years: 7 — Months: 10 — Days: 6 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John P. Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Catherine Schuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): John P. Reed 1514 N. Spring

15 Filed JUN 17 1921 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15 1921, to June 16 1921, that I last saw h[illegible] alive on June 16 1921, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Diphtheria (Laryngeal)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. E. Brunsteck M. D.

6/69/21 (Address) 1591 E. Northwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: June 17 1921

20 UNDERTAKER: Robt L Turner Inc

ADDRESS 1442 N Broadway

TION is very important. See instructions on back of certificates. ...e properly classified. Exact statement of OCCUPA-...ms, so that it may be ... State

Spec—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54608

CERTIFICATE OF DEATH.

D 54608

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 Mt Royal Terrace ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vashti Sandsbury Garey

(a) RESIDENCE. No. 1902 Mt Royal Terrace ST., WARD. Denton Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Col. Robert Garey

6 DATE OF BIRTH (month, day, and year) May 3rd 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

880

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER James Saulsbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary Hitch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant James A Garey
(Address) 1902 Mt Royal

15 FILED JUN 17 1921 ROBERT B. ERNST, Registrar

Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921 to June 16, 1921, that I last saw her alive on June 16, 1921, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus

(duration) yrs. 3 mos. 4 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Denton, md.

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? microscopical

(Signed) Nathan Winslow, M. D.

, 19 (Address) 1900 Mt Royal Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Denton, Md	June 17 19 21

20 UNDERTAKER John O. Mitchell ADDRESS 124 N Eutaw

NOTE.—It is very important. See instructions on back of certificates. Should State may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54609 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54609

152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3024 Stafford ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas

(a) RESIDENCE. NO. 3024 Stafford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John F. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mississippi

12 MAIDEN NAME OF MOTHER Violet Mayfield Maryland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Violet Mayfield Thomas (Address) 3024 Stafford

15 Filed JUN 17 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1921

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1921, to June 14, 1921, that I last saw him alive on June 14, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Breech Presentation

Twin Delivery

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Kost, M. D.

6/15, 1921 (Address) 418 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Medical School

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificates.

Spmc. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54610

CERTIFICATE OF DEATH.

47

D 54610

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Jenkins ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Thomas Carroll

(a) RESIDENCE. NO. 1110 Jenkins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Jany 27-1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Errand boy in Clothing

(b) General nature of industry, business, or establishment in which employed (or employer) Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sadie Downs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Samuel Carroll
(Address) 1110 Jenkins st

15 JUN 17 1921 ROBERT J. BRAUER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17. 1921. to June 14. 1921. that I last saw him alive on June 14. 1921. and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism

(duration) — yrs. — mos. 28 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pelletreau, M. D.

19 (Address) 829 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	June 17 1921
20 UNDERTAKER J. Snow Hall	ADDRESS 1731 D. Ave

FROM is very important. See instructions on back of certificates. Every question must be properly classified. Exact statement of OCCUPATION may be necessary.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54611

CERTIFICATE OF DEATH.

79

D 54611

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N Carey ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie E. Knapp

(Residence in Baltimore: No. 509 N. Carey St ST.: 30 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Dec 27, 1849. (Month) (Day) (Year)

7-AGE, 71 yrs. mos. da.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~000~~
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Emma H. Jamison

(Address) 1009 W. Lafayette Ave

15-

Filed JUN 7 1921 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14th 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14th 1921, to June 15th 1921, that I saw h-- alive on June 15th 1921, and that death occurred, on the date stated above, at 130 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Exhaustion

(Duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) C. C. Lemmon M. D.

June 15th 1921 (Address) 4 E. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem

DATE OF BURIAL, June 17, 1921.

20-UNDERTAKER Chas. E. Franck

ADDRESS 532 Madison

Case of attachment of OCCUPATION is very important. See instructions on back of certificate.

D 54612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54612

CERTIFICATE OF DEATH.

REGISTERED No. C 183

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1. PLACE OF DEATH (a) CITY OF BALTIMORE (No. Body found in the woods at) (b) (St. Brooklyn Park.) (WARD) 25

2. FULL NAME Edwin G. Gardner.

(Residence in Baltimore: No. 410 Potomac St Brooklyn. St.: yrs. 15 mos. 2 ds. 17)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, March 25th. 1906., 1 (Month) (Day) (Year)

7-AGE. 15 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Brooklyn, Md

PARENTS.

10-NAME OF FATHER, William H. Gardner.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Carrie B. Upton.

13-BIRTHPLACE OF MOTHER (State or Country), A. A. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Gardner. (father)

(Address) 410 Potomac St. Brooklyn.

15-

Filed JUN 17 1921, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Missing June 11, 1921. ....Body found June 15, 1921....., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull and larynx.
Stab wounds about the neck.
Homicide.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Elliott Pennhurst M. D. (Coroner.)

June 16, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
CEDAR HILL.	JUN 17 1921, 19....
20-UNDERTAKER JOHN F. DENNY	ADDRESS 716 LIGHT ST.

Important. See instructions on back of certificate. ...property classified. Exact statement of OCCUPATION is very

D 54613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54613

CERTIFICATE OF DEATH.

1 186

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lot at Cross & Race Sts. ST.: 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence C. Friedhoff.

(Residence in Baltimore: No. 806 N. Mount St.

5 --------

St.; yrs., mos. da.)

IMPORTANT: PHYSICIANS should state particularly and correctly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH. April 4th, 1888, (Month) (Day) 1 (Year)

7-AGE. 33 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Friedhoff. (wife)

(Address) 806 N. Mount St.

15-

Filed JUN 17 1921, 191.... ROBERT A KRAUTH Registrar

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 15th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally struck on the head by the falling of a centre pole of a carousel. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Albert Friedhoff M. D.
(Coroner.)

June 16, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Rock Hall Kent Co. Md.	JUN 17 1921, 19....

20-UNDERTAKER	ADDRESS
JOHN F. DENNY	716 LIGHT ST.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54614

CERTIFICATE OF DEATH.

79 D 54614

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4423 York road ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Leila Brown

(a) RESIDENCE. NO. 4423 York road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Karl Brown

6 DATE OF BIRTH (month, day, and year) Oct 23-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kennett Square Pa

PARENTS

10 NAME OF FATHER Chester B Hatch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Whitehaven Pa

12 MAIDEN NAME OF MOTHER Rebecca Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kennett Square Pa

14 Informant (Address) C. Clinton Brown 4423 York road

15 Filed JUN 17 1921 ROBERT J. BRAUER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1921, to June 14 1921, that I last saw h-d alive on June 11 1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

about 6 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Peterson M. D.

, 19 (Address) 4423 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Cemetery	June 17 1921

20 UNDERTAKER J. Herwig & Co

ADDRESS 2008 Eutaw

IMPORTANT is very important. See instructions on back of certificates. Exact statement of OCCUPATION should be properly classified. Be sure that it may be properly coded.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54615

CERTIFICATE OF DEATH.

54

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1215 N. Bond ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura E Whitehurst

(Residence in Baltimore: No. 1215 N. Bond St.: 57 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. November (Month) 29th (Day), 1851. (Year)

7-AGE. 69 yrs. 6 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country). Queen Anns Co Md

PARENTS.

10-NAME OF FATHER, Elijah C. Bishop

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Adeline Canaan

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James R. Whitehurst

(Address) 1215 N. Bond st

15-

Filed JUN 17 1921 ROBERT J KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 16 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 9, 1921, to June 16, 1921, that I saw her alive on June 15, 1921, and that death occurred, on the date stated above, at 2.40 a m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin B. Fenby M. D.

June 17, 1921 (Address) 1223 N. Caroline St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	June 18th, 1921.
20-UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54616

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 54616

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 Rutland av. ~~St.~~ 7 — WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence H. Steen

(a) RESIDENCE. NO. 723 Rutland av. ~~St.~~ WARD. 7th

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband of Maude Steen

6 DATE OF BIRTH (month, day, and year) April 22-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
43		1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Steen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Hickman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Maude Steen (Address) 723 Rutland Ave

15 Filed JUN 17 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1921, to June 14, 1921, that I last saw him alive on June 14, 1921, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

June 14, 1921 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 18 1921
20 UNDERTAKER	ADDRESS
William Gehnal	816 Fremont

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54617

CERTIFICATE OF DEATH.

Peace 2 45-Brooley

92 D 54617

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 South Hill ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Willis

(a) RESIDENCE NO. 217 South Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sophia Willis

6 DATE OF BIRTH (month, day, and year): Sept 12 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	64	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steward 186

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Steamships Co

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Henry Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Sophia Willis

(Address) 219 South Conn

15 Filed JUN 17 1921 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1921

17

I HEREBY CERTIFY, That I attended deceased from June 15 1921 to June 16 1921, that I last saw h-- alive on June 16 1921, and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) A. Friis, M. D.

June 16 1921 (Address) 24 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. L. Carroll — DATE OF BURIAL: 6-19 1921

20 UNDERTAKER: William Cole — ADDRESS: 502 E Mont

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54618

CERTIFICATE OF DEATH.

64 D 54618

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 South 13th St.; 7th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Akers

(a) RESIDENCE. No. 417 S. 13th St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed or divorced — HUSBAND of (or) WIFE of: John W. Akers

6 DATE OF BIRTH (month, day, and year): Sept 23 1857

7 AGE — Years: 63 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Benj Falwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Melinda Warren

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Edith Akers 417 S. 13th

15 Filed JUN 17 1921 19 — BOWEN & KRAUTER Registrar — Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1921

17 I HEREBY CERTIFY, That I attended deceased from June 12. 1921. to June 16. 1921. that I last saw her alive on June 16 1921. and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

4 ds. (duration) yrs. mos.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod M. D.

19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	6-20 1921
20 UNDERTAKER: Wareham Cook	ADDRESS: 502 E Hoffman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 54619

HEALTH DEPARTMENT—CITY OF BALTIMORE

61-001 D 54619

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1422 Argyle Ave ST.: 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian F. Thomas

(Residence in Baltimore: No. 1422 Argyle Ave. St.; 18 yrs., 4 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: Feb. (Month) 11 (Day), 1903 (Year)

7-AGE: 18 yrs. 4 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stenography
(b) General nature of industry, business, or establishment in which employed (or employer): Office

9-BIRTHPLACE (State or Country): Balto. Md.

PARENTAGE

10-NAME OF FATHER: Lloyd Thomas

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Mary Cole

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry L. Cole

(Address) 1422 Argyle Ave

15- Filed JUN 17 1921, 191.... ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro-spinal Meningitis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. T. Hennessy M. D. (Coroner.)

June 16. 1921 (Address) 2813 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Zion Cemetery

DATE OF BURIAL: June 17 1921

20-UNDERTAKER: Jno. M. Johnson

ADDRESS 1231 Eutaw St.

IMPORTANT. See instructions on back of certificate. Answers must be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Christopher Frederick Eimer (See affadavit over)

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54620

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eimer

(a) RESIDENCE. NO. 1823 Warwick Av. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Eimer

6 DATE OF BIRTH (month, day, and year): Aug 16-1856

7 AGE — Years: 64 — Months: 10 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 078

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: United Rwys.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: George Eimer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Matilda Fritz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Eimer (Address) 1823 Warwick Ave

15 Filed JUN 17 1921 ROBERT J. KRAUTER Registrar

Burial Permit 01691

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1921, to June 16, 1921.

That I last saw h[illegible] alive on June 16, 1921.

and that death occurred, on the date stated above, at 4:45 A m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Septicemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis L. Edgar, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jmeso 1921
20 UNDERTAKER	ADDRESS
Geo. A. Schmelz & Bro	2101 Eutaw Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA[illegible] properly classified. PHYSICIANS should state in plain terms, so that it may be

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Septicaemia due to pyelitis. No further history.

Baltimore, Md.

July 21, 1921

This is to certify that the
death certificate in the case
of Fred Eimer who died at
Mercy Hospital June 16 1921
of Pyelitis & Septicaemia
should be corrected to
Christopher Frederick Eimer

Francis X Kearney M.D.

STATE OF MARYLAND, CITY OF BALTIMORE, to wit:-

I HEREBY CERTIFY that on this 24 day of July in the year one thousand nine hundred and twenty one, before me the subscriber a Notary Public of the State of Maryland in and for the City of Baltimore aforesaid, personally appeared Francis X. Kearney, M.D. and made oath in due form of law that the above facts are true as therein states to the best of his knowledge and belief.

WITNESS my hand an Notorial Seal

Luster Mary Lewis
Notary Public.

Baltimore, Md.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54621

CERTIFICATE OF DEATH.

64

D 54621

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 Edgewood St.; 46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs H Johnson

(Residence in Baltimore: No. 625 Edgewood Ave St.; 73 yrs.. mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Widow

6-DATE OF BIRTH, ... May (Month) 31 (Day) 1847 (Year)

7-AGE,	If LESS than 1 day,
..... 73 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Samuel Johnson

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Susan Wignott

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Geo Coggins

(Address) 625 Edgewood St

15- Filed JUN 17 1921 191.... ROBERT I KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1921, to June 14th 1921, that I saw him alive on June 14th 1921, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Apoplexy)

(Duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) High Blood Pressure Chronic Nephritis

(Duration) 4 yrs. ... mos. ... ds.

(Signed) Henry B Cook M. D.

June 15, 1921 (Address) 1203 Light

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Dist Allen & Cem	6-17... 1921
20-UNDERTAKER	ADDRESS
E B Hart	45 E Lex St

Co 585

Use instructions on back of certificate. Carefully classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54622

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54622

151

CERTIFICATE OF DEATH.

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital St.; 9 WARD)

2-FULL NAME Baby Griffin

(a) RESIDENCE. No. 1809 W Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 15 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day 9 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Paul Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Myrtle VanSant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Paul Griffin
(Address) 1809 W Lexington

JUN 17 1921

ROBERT J. BRUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/16/1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to June 15, 1921, that I last saw h[illegible] alive on June 15, 1921, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank C Irwin M. D.

. 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 18 1921
20 UNDERTAKER F. A. Kranse & Son	ADDRESS 703 Hanover

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54623 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54623

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David E. King.

(a) RESIDENCE. No. 1182 Montecute St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) June 3, 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired, ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER David E. King.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ✓

14 Informant Clinton E. King. (Address) 1182 Montecute.

15 Filed JUN 17 1921 ROBERT E. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-10, 1921, to 6-15, 1921, that I last saw h... alive on 6-15, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Tumor Cachexia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 6-10-21

Was there an autopsy? ✓

What test confirmed diagnosis? Operation

(Signed) Reb. W. Hooper, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 18 1921

20 UNDERTAKER F. A. Krause & Son ADDRESS 759 Hanover St

Note.—Very important. See instructions on back of certificates.

Mr. Margaretha Rauburger

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54624

CERTIFICATE OF DEATH.

79 D 54624

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaretha (married) Rosenberger (Mother)

(a) RESIDENCE. NO. St Josephs Home ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nicholas Jacob Rosenberger

6 DATE OF BIRTH (month, day, and year) Oct 5 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant M. J. Harry Rosenberger
(Address) 2052 Kenwood Ave

15 Filed JUN 17 1921, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/16/1921

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1921, to June 16, 1921, that I last saw h.. alive on June 16, 1921, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.M. & Symptoms

(Signed) Paul C Barnes, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 18 1921

20 UNDERTAKER Henry Hoech Son ADDRESS 130, E Lanvale

HOW IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54625

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) East Franklin and near Belair Road (St.) (Ward)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert C Sutherlet

(a) RESIDENCE. No. East Franklin and near Belair Road St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. 24 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida A. Sutherlet

6 DATE OF BIRTH (month, day, and year) May 22, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Straw Hat Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Hat

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August Sutherlet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Etzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ida A Sutherlet

(Address) Franklin Ave near Belair Rd

15 Filed JUN 17 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1921

17

I HEREBY CERTIFY, That I attended deceased from During past 2 Years, 1919.

that I last saw h[illegible] alive on June 16, 1921.

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema, Uremia

(duration) yrs. mos. 1 Day

18 Where was disease contracted if not at place of death? c

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Theo Tolleson M.D.

Address 3450 Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 20 1921

20 UNDERTAKER Henry Hoeck Son

ADDRESS 1301 E Fayette

Buried Female Ward

Important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54626

CERTIFICATE OF DEATH.

98 D 54626

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Madison Ave ST.: 14 WARD)

2-FULL NAME Lulu Hoover Thornton

(a) RESIDENCE. No. 1401 Madison Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
female	white	married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Jas T. Thornton

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Pierce Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Indiana V. Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Carlisle M. Thornton
(Address) 1401 Madison Ave.

15 Filed JUN 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1921, to June 16, 1921, that I last saw h.. alive on June 16, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Theo. H. Morrison, M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 18 1921
20 UNDERTAKER	ADDRESS
Henry J. Jenkins Sons Co.	McCulloh & Oreland

Burial Permit Clerk

Note—Is very important. See instructions on back of certificates.

Form 6-9-19—H. P. Co.—1000 Bks.

D 54627

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

184 D 54627

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 S. Montford Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genowefa Borkowski

(a) RESIDENCE. No. 735 S. Montford ave ST., 1, WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Joseph Borkowski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Katharine Powlat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Joseph Borkowski.
(Address) 735 S. Montford ave.

15 Filed JUN 17 1921 ROBERT J. KRAUTER Registrar

Burial [illegible] Olark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10 1921 to June 16 1921

that I last saw her alive on June 16 1921 at 4.30 P.M.

and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Brown, M. D.

19 (Address) 1 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	June 17" 1921.

20 UNDERTAKER W. F. Sadowski. ADDRESS 705 S. Ann

How is very important. See instructions on back of certificates. Full statement of OCCUPA

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54628

CERTIFICATE OF DEATH.

D 54628

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1708 E. Biddle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H Wilkens

(a) RESIDENCE. No. 1708 E Biddle ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Wilkens

6 DATE OF BIRTH (month, day, and year) July 3 1885

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	35	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) Crane Operator

(c) Name of employer F S. Royston Baltimore

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Oliver H. Wilkens

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Faller

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Herbert Wilkens (Address) 1708 E Biddle St

15 Filed JUN 17 1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1921

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1920. to June 14. 1921.

that I last saw h living on June 13. 1921.

and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. Direct ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. E. Hoshall M. D.

June 19 21 (Address) 1301 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 17, 1921

20 UNDERTAKER Geo. J Puth ADDRESS 1235 Harford Ave

THIS is very important. See instructions on back of certificates. Be sure to be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54629

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54629

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. U. of Md Hospt ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Lee Clemens

(a) RESIDENCE. No. 628 Guilford Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) 4/16/21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2 mos	2-mo	/	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ---

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm Clemens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anne Brewer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parents above (Address)

15 Filed JUN 17 1921 19 ROBERT J. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16- 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to June 16, 1921, that I last saw h[illegible] alive on June 16, 1921, and that death occurred, on the date stated above, at 4 01 m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) ---

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm McGill, M. D.

, 19 (Address) U. of Md Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cem.	6/17/21

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Harford Ave

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 54630

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2109 N. Pulaski ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Emma Conley

(a) RESIDENCE. No. 2109 N Pulaski ST., 15 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fredrick Conley

6 DATE OF BIRTH (month, day, and year) 5-3-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Spinner 086

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Mill

(c) Name of employer Wm E. Hooper & Sons Balto

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James E. Porter

11 BIRTHPLACE OF FATHER (city or town) Rochester (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Moore

13 BIRTHPLACE OF MOTHER (city or town) Rochester (State or country) Md.

14 Informant Benj F. Schuh (Address) 1097 Pulaski

15 Filed JUN 17 1921 ROBERT J. KRAUTER Registrar

Burial Permit Oiled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 16 1921, that I last saw her alive on June 15 1921, and that death occurred, on the date stated above, at 12 00 p m.

The CAUSE OF DEATH* was as follows:

(a) Diabetes Mellitus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs

(Signed) Ed Heer M. D.

6/16/21 (Address) 4085 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Marys Cemetery	June 17th '21
20 UNDERTAKER	ADDRESS
Louis Heumann	32 S. Broadway.

Check of certificates. See instructions on back of this. Very important. [illegible] & OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54631

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54631

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1405 Jackson St. 24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma Marjorie Lontz.

(a) RESIDENCE. NO. 1405 Jackson ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Charles Lontz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland.

14 Informant Charles Lontz
(Address) 1405 Jackson St.

15 Filed JUN 17 1921 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1921

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1921, to June 15, 1921.

that I last saw h alive on June 15, 1921.

and that death occurred, on the date stated above, a) m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs.

(Signed) Sidney H. Strutt M. D.

6/16. 1921 (Address) 405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hills	June 17 1921
20 UNDERTAKER	ADDRESS
Margaret J. Lyons	1711 Eight St.

THIS IS very important. See instructions on back of certificates. Exact statement of OCCUPA- property classified.

Edith Trelick

Size 6-9-19—H. P. Co.—1000 Blks.

19 54632 HEALTH DEPARTMENT—CITY OF BALTIMORE 21 D 54632

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Trelick

(a) RESIDENCE. No. 803 N Gay St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Trelick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ray Tiemance

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J.H.H. Records

15 Filed JUN 17 1921 . 19 Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16 . 1921, to June 17. 1921.

that I last saw her alive on June 17 . 1921.

and that death occurred, on the date stated above, at 3:20 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

6-18-21 . 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Workmen Circle	June 17 1921
20 UNDERTAKER	ADDRESS
Jack Lewis, 1411	E. Balto

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history of anything further. So far as phy. could determine only broncho pneumonia.

Spest.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54633

CERTIFICATE OF DEATH.

64 D 546333

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital. St.: 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Connolly

(a) RESIDENCE. No. 14 Gorman Av St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Do not know

6 DATE OF BIRTH (month, day, and year) June 24 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	~~Do not know~~ 4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. ~~Do not know~~ 640

(b) General nature of industry, business, or establishment in which employed (or employer) " " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. " Md "

PARENTS

10 NAME OF FATHER John Connolly.

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) " " Md

12 MAIDEN NAME OF MOTHER Mary Schillinberg.

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) " " Md

14 Informant Mrs. Connolly

(Address) 14 Gorman Ave

15 Filed JUN 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15- 1921

17

I HEREBY CERTIFY, That I attended deceased from 3-26 1921 to 6-15 1921

that I last saw him alive on 6-15 1921

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

(Apoplexy.)
Cerebral haemorrahage.

(duration) ~~5~~ yrs. 2 mos. 19 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? urine - tests.

(Signed) Dudley P. Bowe, M. D.

. 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: June 19 1921

20 UNDERTAKER: E. P. Fanning & Son — ADDRESS: 1461 Battery Av.

Burial Permit Issued

FROM BIRTH CERTIFICATE OR PARENT. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54634 HEALTH DEPARTMENT—CITY OF BALTIMORE 1 D 54634

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 N Bartlett St. ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Vesely

(a) RESIDENCE. No. 136 N Bartlett

(Usual place of abode) ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Vesely

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 72; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 937

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Frank Mazna

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Anna Bosturi

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): John Vesely 136 N Bartlett St

15 JUN 17 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1921, to June 15, 1921, (that I last saw her alive on June 14, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

6-15-21 Address 500 N Bell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 17 1921

20 UNDERTAKER: Frank Erschen — ADDRESS: 1906 Eastern Ave

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. Be careful to have every question properly answered.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54635

CERTIFICATE OF DEATH.

109

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. No. Provident Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lela Pratt

(a) RESIDENCE. No 1116 N. Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Pratt

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Nurse~~ at home

(b) General nature of industry, business, or establishment in which employed (or employer) wife 037

(c) Name of employer and

9 BIRTHPLACE (city or town) (State or country) Ohio Griffin

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) md. A.A. Co

12 MAIDEN NAME OF MOTHER Annie E. Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md. and

14 Informant Elsie Griffin (Address) 1116 N. Carey St

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 5 1921, to June 15, 1921, that I last saw h.. alive on June 5, 1921 and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Instestinal Obstruction, Sequel to Adhesions (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Stock (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? yes Date of June 15

Was there an autopsy? no operation

What test confirmed diagnosis?

(Signed) [illegible] M. D.

June 21, 1921 (Address) 1713 Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harmon Chapel A.A. Co	June 18 1921
20 UNDERTAKER	ADDRESS
George T. A. Gibson	573 Fairmount Av

TION is very important. See instructions on back of certificates.

D 54636

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54636

CERTIFICATE OF DEATH.

169

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Light Street Wf. ST. 3 WARD)
REGISTERED NO. C.
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.))

2-FULL NAME Vincent Santa

(Residence in Baltimore: No. 218 S. Light St.)

3(yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	Child

6-DATE OF BIRTH, Dec 10, 1911.
(Month) (Day) (Year)

7-AGE, 10 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Angelo Santa

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosie Bandetto

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Angelo Santa

(Address) 218 S. Light St.

15-
Filed ....., 191.... Robert P. Harrison,
Registrar.

N 1 1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident Drowning

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) F. Clinton Peters M. D.
(Coroner.)

June 16 1921. (Address) 743 N. Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....da. In the State....yrs....mos....da.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincents Cemetery	June 17. 1921.
20-UNDERTAKER	ADDRESS
Wendel & Appel & Son	37 S. Carrollton

Important. See instructions on back of certificate.

Stamp—6-9-19—H. P. Co.—1000 Blks.

148 843
D 54637

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. (St.:) 7 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Findlay

(a) RESIDENCE. No. 20 N. Gilson St. Canandaigua N.Y. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep. 12. 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Geo Findlay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Emma Daggo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant (Address) Mrs. Burns

15 Filed 19 Robert P. Harrison, Registrar
7 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1921, to June 17, 1921, that I last saw h alive on June 17, 1921, and that death occurred, on the date stated above, at 150 P m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) W E Sandy, M. D.

6/17/21, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rochester N.Y.	6/17 21
20 UNDERTAKER	ADDRESS
H E Wyles & Co	Rochester N.Y.

Instructions on back of certificates. Exact statement of occupa-

D 54638 (Garcia) D 54638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 1007 Bush St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola M Garcia

(Residence in Baltimore: No. 1007 Bush St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Sept (Month) 23 (Day) 1904 (Year)

7-AGE, 16 yrs. 9 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, August Hurley

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Catherine Chenwith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Weller

(Address) 1007 Bush St

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

NT 71921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hydrocephaloid Convulsions
Duration 1 hr 7 days
Encephalitis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. 8 ds.

(Signed) James M Flynn M. D. (Coroner.)

June 17, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? Light House St

Former or usual residence 1007 Bush St

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Loudon Park	June 18, 1921
20-UNDERTAKER Margaret E. Flynn	ADDRESS 700 E Chase St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54639

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54639

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1355 Hull St. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Agnes McGuire

(a) RESIDENCE. No. 1355 Hull St., WARD. 24

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 8-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Michael McGuire

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant J. Ross, M.D. (Address) 1202 W. North Ave.

15 Filed Robert P. Harrison, Registrar

171921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16-1921

17 I HEREBY CERTIFY, That I attended deceased from 5-16-, 1921, to 6-16, 1921, that I last saw h[illegible] alive on 6-15, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None needed.

(Signed) Thomas J. Ross, M. D.

6-16 1921 (Address) 1202 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 18 1921

20 UNDERTAKER Margaret J. Flynn ADDRESS 1[illegible] W. [illegible] St.

Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54640 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54640

CERTIFICATE OF DEATH. 105

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1623 Milliman ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo E. Robinson

(a) RESIDENCE. No. 1623 Milliman ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? ~~yrs~~ ~~mos~~ ~~ds~~

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not any yet

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo. H. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lillian E. Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs Lillian Anderson 1623 Milleman St.

15 Filed 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 12. 1921. to June 17. 1921. that I last saw h~~im~~ alive on June 16. 1921. and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal catarrh

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

6/17. 1921 (Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	June 18 1921
20 UNDERTAKER Mrs J. G. Locke	ADDRESS 1302 Jefferson

Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54641

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54641

CERTIFICATE OF DEATH.

137

1-PLACE OF DEATH University Hospital.

CITY OF BALTIMORE: (No. Lombard & Green Sts ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachal · Hall

(a) RESIDENCE. No. 512 Baker St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 1 mos. ds. How long in U. S., if of foreign birth? 36 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alonzo Hall

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Ennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Frances Canaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Alonzo Hall

(Address) 512 Baker St

15 Burial Permit Clerk. 8, 1921

Registrar Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to June 17, 1921.

That I last saw her alive on June 16, 1921.

and that death occurred, on the date stated above, at 5 40 A m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Hundley Jr., M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Bier. Cemetery	June 19 21
20 UNDERTAKER James. H. Dennis	ADDRESS 1303 Presstman

This is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54642 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54642

CERTIFICATE OF DEATH.

REGISTERED NO. 55

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.; 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Baker

(a) RESIDENCE. No. Shenandoah Co. St., Ward. Shenandoah Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5 1870

7 AGE: Years 51 Months — Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER J. W. Harlenstine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Supt Revd (Address)

15 JUN 18 1921 Robert P. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4. 1921. to June 17. 1921.

that I last saw h[illegible] alive on June 17. 1921.

and that death occurred, on the date stated above, at 11 05 A m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis X. Kearney, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shenandoah Va — DATE OF BURIAL: 6/18/21

20 UNDERTAKER: Geo E Farley Sutton — ADDRESS: Staunton Va

INSTRUCTIONS ON BACK OF CERTIFICATE.

D 54643

D 54643

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2724 A Donell ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Jednoralski

(a) RESIDENCE. NO. 2724 A Donell ST. 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 9-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			8	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work None 700

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Jednoralski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ida Kendzejewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Adam Jednoralski
(Address) 2724 A Donell St

Filed N 18 1921, 19

Robert P. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1921, to June 17, 1921.

that I last saw him alive on June 13, 1921.

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(7 mos)
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. S. Hill, M. D.

, 19 (Address) 4085 Pabbk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	June 19 1921
20 UNDERTAKER	ADDRESS
Stephen L Fialkowski	1005 Kenwood

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54644

CERTIFICATE OF DEATH.

42

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3716 Elm Ave. ST.: 13 WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cindarella Johnson

(a) RESIDENCE. No. 3716 Elm Ave. ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs — mos — ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John D. Johnson

6 DATE OF BIRTH (month, day, and year): Nov. 12-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Wm. Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth Dumaranville

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Mrs. John D. Johnson 3716 Elm Ave.

15 Filed: 1 8 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1921

17 HEREBY CERTIFY, That I attended deceased from April 1, 1921, to June 16, 1921

that I last saw h er alive on June 15, 1921

and that death occurred, on the date stated above, at 8 20 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) yrs. 2 mos. 16 ds.

18 Where was disease contracted if not at place of death? 3350 E Lexington St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. F. Congdon, M. D.

6-17 1921 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	June 18 1921
UNDERTAKER	ADDRESS
Horace F. Burgee	3631 Falls Rd

See instructions on back of certificates.

Spec.—6-5-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54645

CERTIFICATE OF DEATH.

29 D 54645

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3443 Roland Ave. (St.) 13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane T. Brannan

(a) RESIDENCE. No. 3443 Roland Ave. St., 13 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Wm. A. Brannan

6 DATE OF BIRTH (month, day, and year): June 14-1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 800

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thaddeus Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Alice Morse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Rose T. Brannan

(Address): 3443 Roland Ave.

15 Filed 8 1921

Robert P. Harrison,
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1921, to June 17, 1921, that I last saw h[illegible] alive on June 17 1921, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) C F Hinshaw, M. D.

June 21, 1921 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 20 1921
UNDERTAKER	ADDRESS
Horace A. Burgee	363 Falls Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54646

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54646

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 3605 Central Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Proctor

(a) RESIDENCE. No. 3605 Central Ave ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs — mos — ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Proctor

6 DATE OF BIRTH (month, day, and year): Sept 30-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter, J'

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Maryland

PARENTS

10 NAME OF FATHER: Henry Proctor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER: Rachael Sellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md.

14 Informant (Address): Mrs. Clara Proctor 3605 Central Ave.

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 1921

17

I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to June 17, 1921, that I last saw him alive on June 16 1921, and that death occurred, on the date stated above, at 12 15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cystitis following prostatectomy Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. H. Machen, M. D.

, 19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 21 1921

20 UNDERTAKER: Horace H. Burgee ADDRESS: 363 Falls Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54647 (Ofriau) CERTIFICATE OF DEATH 8,0911 54647

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. 914 E. Lombard St. 3D WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Peter Ofriau

(Residence in Baltimore: No. 914 E. Lombard St.: One yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Infant

6 DATE OF BIRTH: Aug (Month) 24 (Day), 1919 (Year)

7 AGE: One yrs. 9 mos. 23 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
000

9 BIRTHPLACE (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Ofriau

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER Markowitz

13 BIRTHPLACE OF MOTHER (State or country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anthony Ofriau.

(Address) 914 E Lombard St

15.

Filed ..... 1921 Robert P. Harrison, REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 17 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to June 17 1921. that I saw h[illegible] alive on June 17, 1921. and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pertussis

Not Known
(Duration) ... yrs. ... mos. ... ds.

Contributory (SECONDARY) Bronchopneumonia

(Duration) 1 yrs. mos. 4 ds.

(Signed) Herman Seidel M. D.

June 17, 1921 (Address) 2404 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 19, 1921

20 UNDERTAKER: John Gebhimer — ADDRESS: 425 S. Paca St.

IS VERY IMPORTANT. See instructions on back of certificate. ... it may be properly classified. Exact statement of OCCUPATION ... PHYSICIANS should ... PLAINLY, ... plain terms, so that it ...

Spec.—8-24-14—M. & T.—2000 Bks.

D 54648

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D 54648

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 212 N. Central Ave St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Brown

(Residence in Baltimore: No. 212 N Central Ave St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, —— (Month) —— (Day) 1 (Year)

7-AGE, 67 yrs. —— mos. —— ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) House Work

9-BIRTHPLACE, (State or Country), Living Balt 40 years North Carolina

PARENTS.

10-NAME OF FATHER, Alfred Jones

11-BIRTHPLACE OF FATHER (State or Country), N Carolina

12-MAIDEN NAME OF MOTHER Cherry Dorsey

13-BIRTHPLACE OF MOTHER (State or Country), N Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cherry Gadey

(Address) 212 N Central Ave

15-

Filed 8 1921 Robert P. Harrison. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 10 1921, to June 16 1921, that I saw h or alive on June 16 1921, and that death occurred, on the date stated above, at 630 p. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

Contributory Hypertension

(Duration) 1 yr 2 mos. ds.

CONTRIBUTORY Hypertension
(Secondary)

(Duration) Several yrs. mos. ds.

(Signed) E H Miller M. D.

June 17 1921 (Address) 607 N Carey St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, June 19 1921

20-UNDERTAKER Geo Robert A Elliott

ADDRESS 1725 Ashland Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54649

D 54649

113

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 N Milton Ave Sta 6 WARD)

2-FULL NAME Margaret (Gardner) Gaertner

(a) RESIDENCE. No. 234 N Milton Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? supp mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Edmund Gaertner

6 DATE OF BIRTH (month, day, and year) June 19-58

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry Lutz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elsie Gaertner

(Address) 234 N. Milton a

15 Filed 181921 Robert P. Harrison, M. D. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/16/21

17 I HEREBY CERTIFY, That I attended deceased from Mar-1- 1921. to June 16. 1921.

that I last saw h.r alive on June 15 1921.

and that death occurred, on the date stated above, at 7.05 p. m.

The CAUSE OF DEATH* was as follows:

Hyper. Cirrhosis Liver

(duration) yrs. mos. 1 wks. da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Dr Craw,

What test confirmed diagnosis? Dr Craw,

(Signed) F. Claude Blades M. D.

6/16/21 (Address) 1436 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 20 1921
20 UNDERTAKER Philip Herwig	ADDRESS 206 Aisquith

Use typewriter for entries. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54650

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54650

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 Grindon Lane ST., 7 WARD)

Lauraville

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth L. Arniger

(a) RESIDENCE. NO. 20 Grindon Lane WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 1 mos. 9 ds. How long in U. S., If of foreign birth? 52 yrs. 1 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Frank Arniger

6 DATE OF BIRTH (month, day, and year) May 7-69

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER August Hillebrandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Frank Arniger 20 Grindon Lane

15 Filed 8 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1921

17 I HEREBY CERTIFY, That I attended deceased from January 17th 1921 to June 15th 1921 that I last saw h[illegible] alive on June 15th 1921 and that death occurred, on the date stated above, at 12-30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) Amelia E. Lurk, M. D.

, 19 (Address) 1717 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	June 18 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

Instructions on back of certificates. Statement of OCCUPA

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54651

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 E Federal ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Adler

(a) RESIDENCE. NO. 1811 E Federal ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Louis Zufall

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Thurston

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs Sheeler
(Address) 1811 E Federal

15 Filed Jun 17 1921

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17th 1921

I HEREBY CERTIFY, That I attended deceased from June 17th 1921 to June 17th 1921

that I last saw h alive on June 17th 1921.

and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Prob

(duration) yrs. mos. 10 days

CONTRIBUTORY (Secondary) Senile

(duration) yrs. mos. 10 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Fisher, M. D.

Jun 17 1921 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery Inc	June 20 1921
20 UNDERTAKER Robt Johnson	ADDRESS 1X X 2nd St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54652 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54653

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 W. Camden St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Russell

(a) RESIDENCE. NO. 14 W Camden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Russell

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Oil

(b) General nature of industry, business, or establishment in which employed (or employer) merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Josephine Welder (Address) 14 W. Camden St.

15 Filed ... 19 ... Registrar

JUN 8 1921 Robert P Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23rd, 1921, to June 16, 1921, that I last saw h im alive on June 15, 1921, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Wade E Greengler, M. D.

, 19 (Address) 1013 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 18 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette St.

...ck of certificates.

Spec.—6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54653

D 54653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JEPTHA HUDLEY CRAWFORD

(a) RESIDENCE. NO..... MARSHALL, TEXAS ST., WARD. Marshall Texas

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Bettie Crawford

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE: 30 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oil Well

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Texas

PARENTS

10 NAME OF FATHER: Jeptha Hudley Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Texas

12 MAIDEN NAME OF MOTHER: Mary Key

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Texas

14 Informant (Address): Hospital Record Robert L. Harrison

15 Filed 81921 . 19 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17 1921

17 I HEREBY CERTIFY, That I attended deceased from JUNE 15 . 1921 , to JUNE 17 . 1921 .

that I last saw h 17 alive on JUNE 17 . 1921 .

and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

PELLAGRA

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? .....

What test confirmed diagnosis?

(Signed) J. R Mason , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Marshall Texas — DATE OF BURIAL: June 19 1921

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W Tex

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54654 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 64 D 54654

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 664 Haw ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Dixon

(a) RESIDENCE. NO. 664 Haw ST.. WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Alexander W. Dixon

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alexander Dixon (Address) 664 Haw

15 Date 6/19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1921

17 I HEREBY CERTIFY, That I attended deceased from December 3, 1920, to June 15, 1921, that I last saw h[illegible] alive on June 13, 1921, and that death occurred, on the date stated above, at 11[illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Gen. arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hamp[illegible] M Card M. D.

, 19 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Cemetery	6/19 1921
20 UNDERTAKER	ADDRESS
Thos Gr Hooper	406 W Conway st

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 54655
3 v 655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 132
3 v 655
K 97 D 54655

1-PLACE OF DEATH University Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. Lombard & Green Sts ST.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Zelma Jenkins

(a) RESIDENCE. NO. Westminster Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Fred Jenkins

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Byers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosa Franke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Frederick D. Jenkins
(Address) Westminster, Md.

15 Filed JUN 19 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to June 18, 1921, that I last saw her alive on June 18, 1921, and that death occurred, on the date stated above, at 7 20 P m.

The CAUSE OF DEATH* was as follows:
Double Lobar Pneumonia
0782

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bilateral Salpingitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos Hundley Jr., M. D.

, 19 (Address) University Hospital Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Taylorsville Cemetery. Carroll Co. Md.	June 21st 1921
20 UNDERTAKER	ADDRESS
C. M. Wolfe	Winfield Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause unknown.
Not puerperal.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54656

CERTIFICATE OF DEATH.

40

D 54656

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1026 N. Monroe St.; 16 WARD)

2-FULL NAME Mary E. Yingling

(a) RESIDENCE. NO. 1026 N. Monroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Marie E. Yingling

6 DATE OF BIRTH (month, day, and year) Jan - 24 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Matthew White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah J. Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sarah V. Yingling
(Address) 1026 N. Monroe St

15 Filed JUN 19 1921, 19
ROBERT I. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June - 16, 1921

17 I HEREBY CERTIFY, That I attended deceased from June - 1, 19 20, to June - 16, 19 21,

that I last saw h... alive on June - 16, 19 21,

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) ... yrs. 9 mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Wm. W. Stark, M. D.

, 19 (Address) 2211 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: June 20 1921

20 UNDERTAKER: William Cook

ADDRESS: 507 E. Lafayette Ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54657

CERTIFICATE OF DEATH.

79 D 54657

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3205 (Brighton) ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl A. Greenwood

(a) RESIDENCE. NO. 3205 Brighton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Toni L. Greenwood

6 DATE OF BIRTH (month, day, and year): Jan 7-1865

7 AGE: Years 55 Months Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Model Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

086

PARENTS

9 BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Toni L. Greenwood
(Address) 3205 Brighton St

15 Filed JUN 19 1921 ROBERT A. LAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18th 1921

17 I HEREBY CERTIFY, that I attended deceased from June 16th, 1921, to June 18th, 1921, that I last saw him alive on June 18th, 1921, and that death occurred, on the date stated above, at 6.40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 8 d

CONTRIBUTORY (Secondary) Chr. Mitral Insufficiency (duration) 2 yrs. mos. 7 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo. H. Jaquenbach M. D.

6-18, 1921 (Address) 2215 N. Howard Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: June 21 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E. Wash. Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54658

CERTIFICATE OF DEATH.

30 D 54658

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 617 So. Lakewood Ave. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada. Eliz. Schultze.

(a) RESIDENCE. No. 617 So. Lakewood Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May. 11- 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packing Cans 686

(b) General nature of industry, business, or establishment in which employed (or employer) Southern Can Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salto.

PARENTS

10 NAME OF FATHER Wm. F. Schultze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Emma Pummel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Salto. Md

14 Informant (Address) Wm. Schultze 617 So. Lakewood Ave.

15 Filed JUN 19 1921 ROBERT A. KRAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/17 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1 1921, to 6/17 1921, that I last saw h[illegible] alive on 6/16/21, and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) Philip B. Fowler, M. D.

6/18, 1921 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 20 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E. North

THIS IS very important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D 54659

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 54659

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 E. Hoffman 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm B. DeHoff

(a) RESIDENCE No. 1010 E Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) June 18, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs or min.
	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert. DeHoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Rose Drane

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Robert DeHoff (Address) 1010 E Hoffman

15 Filed ....., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1924, to June 18, 1924, that I last saw him alive on June 18, 1924, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

6 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Maurice E. Shamer M. D.

6/18, 1924 (Address) 3300 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glen Rock Pa DATE OF BURIAL June 9 1924

20 UNDERTAKER ADDRESS

Wm Cook 60 E North

Drive in auto

See instructions on back of certificates. EXACT statement of OCCUPA-

Stmt. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54660

CERTIFICATE OF DEATH.

X 176 ✓ D 54660

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. St. | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Conrad Kuntz

a) RESIDENCE. No. Woodlawn, Md. St. WARD. Woodlawn Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice V. Kuntz

6 DATE OF BIRTH (month, day, and year): May 20 184[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	—	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Jacob Kuntz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant: Mrs Alice V. Kuntz

(Address): Woodlawn Md

15 JUN 19 1921 ROBERT J. BRUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3 . 1921 . to June 18 . 1921 . that I last saw h[illegible] alive on June 18 . 1921 . and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate

duration 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical —

(Signed) Philibert Artigiani, M. D.

6/18. 1921 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olive Roslyn	June 21 1921
20 UNDERTAKER: Jno B Cook	ADDRESS: 1003 W Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54661

CERTIFICATE OF DEATH.

42

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 New ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Flippen

(a) RESIDENCE. NO. 422 New ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant James Dockins

(Address) 422 new St

15 DATE RECEIVED JUN 19 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1921, to June 16, 1921, that I last saw h[illegible] alive on June 15, 1921, and that death occurred, on the date stated above, at 11 55 A m.

The CAUSE OF DEATH* was as follows:

0532

Ca. Abdominal Carcinomata

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Harry A McCard M. D.

6/16. 1921 (Address) 2002 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL June 19 1921

20 UNDERTAKER Samuel I Kennedy ADDRESS 518 N Bridle

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably uterus.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54662

CERTIFICATE OF DEATH.

28 ✓ D 54662

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hosp. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leon Kimmel

(Residence in Baltimore: No. Hebrew Sheltering Home St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. Unknown (Month) (Day), 1909 (Year)

7-AGE. 12 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School boy
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Ida Kimmel

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15- JUN 19 1921 191 ROBERT B. KRAUTH Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4-30 1921, to 6-18 1921, that I saw h[im] alive on 6-18 1921, and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

Peritonitis

(Appendectomy 4-30-18) 18

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(Duration) ? yrs. mos. ds.

(Signed) Charles S. Fay M. D.

June 18, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 20 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? At Bank

Former or usual residence Orphans Asylum

19-PLACE OF BURIAL OR REMOVAL, Hebrew Southern Cem. DATE OF BURIAL, 6/19, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Balto

Nawakowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54663

CERTIFICATE OF DEATH.

64 D 54663

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 818 O Bond St. WARD) 3

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Nawakowski

(Residence in Baltimore: No. 818 O Bond St.) (34 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 53 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer
(b) General nature of industry, business, or establishment in which employed (or employer), 040

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephen Nawakowski

(Address) 818 O Bond St

15- FILED JUN 19 1924 191 Burial Permit Issued
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 17, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Synnestvedt M. D.
(Coroner)

June 18, 1924 (Address) 1000 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, June 20, 1924

20-UNDERTAKER Johnson Weber — ADDRESS 1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54664

HEALTH DEPARTMENT—CITY OF BALTIMORE

1091

104 D 54664

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 S Bond ST.; W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Bogdanowicz

(a) RESIDENCE. NO. 827 S Bond ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4yo yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 18 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 900

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanislaw Bogdanowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Constance

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Stanislaus Bogdanowicz 827 S Bond

15 Filed JUN 19 1921 [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to June 18, 1921, that I last saw her alive on June 18, 1921, and that death occurred, on the date stated above, at 8 0 m.

The CAUSE OF DEATH* was as follows:

Cardio embolism & Thr
embolism

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia & Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Diagnosis & symptoms etc

What test confirmed diagnosis? Diagnosis & symptoms

(Signed) Henry A Bullock M. D.

6/19 1921 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 20 1921

20 UNDERTAKER John A Weber ADDRESS 1803 Bank St

Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D 54665

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D 54665

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 23 Wheeler Ave ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Elizabeth Brockett

(Residence in Baltimore: No. 23 Wheeler Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June 5, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 13 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Gilbert F. Crockett

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Elizabeth C. Shaw

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gilbert F. Crockett

(Address) 23 Wheeler Ave

15- JUN 19 1921 ROBERT S. BRUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 5, 1921, to June 18, 1921, that I saw her alive on June 18, 1921, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Congenital Hernia Tonsa

..... (Duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. F. Dickey M. D.

June 15, 1921. (Address) 1411 Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Guyons Va — DATE OF BURIAL, June 17, 1921.

20-UNDERTAKER Geo. D. Schwab & Bro — ADDRESS 2101 Eutaw Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54666

D 54666

CERTIFICATE OF DEATH.

4 x H1

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Lawrence

(a) RESIDENCE. NO. Seattle, Wash. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Lawrence

6 DATE OF BIRTH (month, day, and year) May 7, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Ofs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Edward Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Eliza Tansey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Hoyt Rutter

(Address)

15 Filed JUN 19 1921 19 LOUIS A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to June 18, 1921, that I last saw h alive on June 18, 1921, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Intestine

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myrcanditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Seattle Wash

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis T. Kearney, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Seattle, Wash	6/19/21
20 UNDERTAKER Geo A Farley	ADDRESS Seattle

Directions for filling out this form are given on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54667

CERTIFICATE OF DEATH.

55-001 D 54667

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 607 W Franklin ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothea Maria Potthast

(Residence in Baltimore: No. 607 W Franklin St.; 8 yrs., 6 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 16, 1912 (Month) (Day) (Year)

7-AGE, 8 yrs. 6 mos. 1 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer)..... HW

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm Potthast

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Leib

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Potthast Father

(Address) 607 W. Franklin St

15- JUN 19 1921 ROBERT J. KRAUTER

..... 191.... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 17, 1921 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jn 16 1921 to Jn 17 1921, that I saw h[illegible] alive on Jn 17 1921, and that death occurred, on the date stated above, at 7.30 p m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(Duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) none

(Duration) — yrs. — mos. — ds.

(Signed) R B Krauter M. D.

Jn 18, 1921 (Address) 609 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Forest Park Cem | DATE OF BURIAL, June 20 1921

20-UNDERTAKER Wm Tarby Sullivan | ADDRESS 1 Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54668

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 54668

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 E. Biddle ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. F. Bonemann

(a) RESIDENCE. No. 1309 E. Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed, or divorced
HUSBAND of (or) WIFE of: John H. W. Bonemann

6 DATE OF BIRTH (month, day, and year): July 4, 1845

7 AGE: Years 75 Months 0 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Peter Guntrum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Ann Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): J. H. W. Bonemann 1309 E. Biddle

15 Filed . 19 JUN 19 1921 BOARD OF HEALTH Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16 19 21 to June 18 19 21 that I last saw h[illegible] alive on June 18 19 21 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis
Acute Endocarditis
(duration) 2 yrs. 4 mos. 14 ds.

CONTRIBUTORY (Secondary) Arthritis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 1309 E. Edgewood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: June 21 1921

20 UNDERTAKER: Zirkler & Zirkler — ADDRESS: 739 Eager

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54669

CERTIFICATE OF DEATH.

79 D 54669

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1806 Harford ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jane Davidson

(Residence in Baltimore: No. 1806 Harford ave St.; 10 yrs., ... mos. ..... ds.)

Life.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, December 24, 1830
(Month) (Day) (Year)

7-AGE, 90 yrs. 5 mos. 21 ds. If ~~LESS than 1 day~~, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Baltimore md

PARENTS.

10-NAME OF FATHER, John Powe

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), U S A

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Warren Daughter

(Address) 1806 Harford ave

15- Filed JUN 18 1921 ROBERT J. BRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 3 1921, to June 17 1921, that I saw her alive on June 16 1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Infirmities of old age

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart Disease

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) H. Hampton Smethurst M. D.

June 17, 1921 (Address) 1615 Harford ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem.	6/20/21, 191...

20-UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54670

CERTIFICATE OF DEATH.

164 D 54670

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 524 S Potomac ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Albert Vanni

(a) RESIDENCE. No. 524 S Potomac ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 26, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Camillo Vanni

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Vigiovanni, Marie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Walter C Bacon
(Address) 100 E 20th St

15 Filed JUN 19 1921 ROBERT J. KRAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to June 18, 1921, that I last saw h in alive on June 15, 1921, and that death occurred, on the date stated above, at 7.30 PM a.m.

The CAUSE OF DEATH* was as follows:

Colitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter C Bacon, M. D.

6/15, 1921 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	6/20/21. 19

20 UNDERTAKER Geo J. Ruth ADDRESS 1735 Hanford Ave.

Back of certificates. Statement of OCCUPA-

Spec.—5-19-13—M. & T.—500 Bks.

Law

HEALTH DEPARTMENT—CITY OF BALTIMORE

104v

CERTIFICATE OF DEATH.

D 54671

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2103 Huntington Ave ST.: ... 12 WARD)

REGISTERED NO. C D 54671

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Louise Law

(Residence in Baltimore: No. 2103 Huntington Ave St.: 1 yrs. 9 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (~~Write the word.~~) Single

6-DATE OF BIRTH, June (Month) 15 (Day), 1921 (Year)

7-AGE, 1 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... — None
(b) General nature of industry, business, or establishment in which employed (or employer) ... — 000

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Wm Smith

11-BIRTHPLACE OF FATHER (State or Country), Penna.

12-MAIDEN NAME OF MOTHER Louise Law

13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ella Law

(Address) 2103 Huntington Ave

15- JUN 19 1921 Filed ... ROBERT J. KRAUTER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 18 1921, to June 18 1921, that I saw h[er] alive on June 18 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows: Bulbo-Encephalitis

(Duration) ... yrs. ... mon. 1 ... da.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ... yrs. ... mos. 15 min. ... da.

(Signed) John Eblaugh M. D.

June 20, 1921 (Address) 710 W Mt Royal Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL, OR REMOVAL, Shrewsbury Pa

DATE OF BURIAL, June 20 1921

20-UNDERTAKER W M Routson

ADDRESS 2238 N Howard

D 54672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175-005

D 54672

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Erdman.

(Residence in Baltimore: No. 504 N. Ellwood Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	S.

6-DATE OF BIRTH, Oct 27 (Month) (Day), 1907 (Year)

7-AGE 13 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At School
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John G. Erdman

11-BIRTHPLACE OF FATHER (State or Country). Balto.

12-MAIDEN NAME OF MOTHER Katherine Berens

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Beren

(Address) 504 N Ellwood Ave

15- JUN 19 1921 ROBERT J KRAUTER

Filed....., 191.... Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic fall of H.
Sood cut.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem	June 20 1921
20-UNDERTAKER	ADDRESS
J Herwig & Co	1008 Aliceanna

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54673

CERTIFICATE OF DEATH.

175-60

D 54673

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland General Hosp. St.: 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rufus Waddell Applegarth

(Residence in Baltimore: No. 227 W Lanvale St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, August 2, 1844
(Month) (Day) (Year)

7-AGE, 76 yrs. 10 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country) Dorchester Co. Md

PARENTS.

10-NAME OF FATHER, Alexander Applegarth

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co Md

12-MAIDEN NAME OF MOTHER Sarah Waddell

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Thomas R Moore

(Address) 227 W Lanvale St

15- JUN 19 1921 ROBERT J KRAUTER

Filed....., 191... Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
(Injury to be fatal June 20, 1921) 2 hrs.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Automobile accident
(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

June 18, 1921. (Address) 200 E Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENCES).

At place of death 1 yrs. 1 mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Accident at Park Heights & Northern Ave.

Former or usual residence 227 W. Lanvale St.

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, June 20, 1921

20-UNDERTAKER Wm. F. Luckman Sons — ADDRESS North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 54674

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Carlton ST.: 16 WARD)

2-FULL NAME Lena A. Covill

(a) RESIDENCE. No. 808 N. Carlton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. A. Covill

6 DATE OF BIRTH (month, day, and year) July 22 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. C. Covill
(Address) 808 N. Carlton St.

15 JUN 19 1921 ROBERT I. GAITHER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1921, to June 17, 1921, that I last saw her alive on June 17, 1921, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter A Cof M. D.

6/18 1921 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 21 1921

20 UNDERTAKER George J. Smith ADDRESS 1000 W. Fayette St

D 54675 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54675

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH REGISTERED No. C.....

CITY OF BALTIMORE (No. 941 Walnut ST.: 17 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Neal Williams

(Residence in Baltimore: No. 941 Walnut St.; 48 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	colored	single

6-DATE OF BIRTH. Unknown (Month) (Day), 1879 (Year)

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter A. Clay

(Address) 941 Walnut St.

15- FILED JUN 20 1921 191.... ROBERT I. GRAFTON Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypertrophic heart disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) No history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

June 18 1921 (Address) 2502 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	June 20, 1921
20-UNDERTAKER	ADDRESS
Daniel Easter	916 Pl

HEALTH DEPARTMENT—CITY OF BALTIMORE

54676

CERTIFICATE OF DEATH.

28 D 54676

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 225 N Bond, ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wiley Thomas

(Residence in Baltimore: No. 225 N Bond. St., 4 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Mal

4-COLOR OR RACE: col.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Aug. 1, 1891
(Month) (Day) (Year)

7-AGE: 29 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country): Columbia S.C.

PARENTS.

10-NAME OF FATHER: John Thomas

11-BIRTHPLACE OF FATHER (State or Country): S.C.

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or Country): unknown

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Ophelia Thomas

(Address) 225 N. Bond St.

15-JUN 20 1921 ROBERT J. [illegible]

Filed....., 191.... Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan. 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. K. Oneale M. D.
(Coroner)

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Asbury Cemetery DATE OF BURIAL: June 20, 1921

20-UNDERTAKER: Chris. H. Lincoln ADDRESS: 46 N. Caroline St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

148920. D 54677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 54677

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Russell.

(a) RESIDENCE. NO. 2017 Eastwood ave ST., Balto md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Emma R. Ruckels same address.

6 DATE OF BIRTH (month, day, and year) Jan 22. 562

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	4	36.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER Wesley Ruckels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth Eckhard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) J. H. Hospital Records.

15 Filed JUN 20 1921 19 ROBT. J. KRAUTER Registrar Social Security Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1921, to June 15, 1921, that I last saw h. alive on June 8, 1921, and that death occurred, on the date stated above, at 12 40 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis (uremia)

(duration) yrs. 1+(?) mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, chronic Nephritis

Lobar pneumonia (duration) 3-10 yrs. mos. ds.

18 Where was disease contracted If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Urine exam, Phthalein & blood Chemistry

(Signed) C. R. Mason, M. D.

6-18-21 6-19-21 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
East Bloomsburg Pa	June 20 1921
20 UNDERTAKER	ADDRESS
Joseph Ahrens	241 Broadway

Spec. 6-9-19—H. P. Co.—1000 Eks.

D 54678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 S. Third ST.: 76 WARD)

REGISTERED NO. ●

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Mack

(a) RESIDENCE. NO. 707 S. Third St. ST., 76 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adam Mack.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Louisa Schreiber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Adam Mack 707 S. Third St.

15 JUN 20 1921 REGISTRAR Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1921, to June 17, 1921.

that I last saw alive on " 16, 1921,

and that death occurred, on the date stated above, at 6.15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. S. Greer M. D.

6/18/21 (Address) 408 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	June 20 1921
20 UNDERTAKER	ADDRESS
Lilly & Son	403 S. Howard St.

Important. See instructions on back of certificates. Exact statement of OCCUPATION properly classified. Should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

Charles Chimbay

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54679

D 54679

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 29 S 11th St ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Chimbay

(a) RESIDENCE. NO. 29 S. 11th — ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dec 9 — 1920

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years	6 Months	9 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chimbay Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mokow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Frank Chimbay 29 S. 11th St.

15 JUN 20 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19 1921

17

I HEREBY CERTIFY, That I attended deceased from 6-16 1921 to 6-19 1921

that I last saw him alive on 6-19 1921

and that death occurred, on the date stated above, at 11:35 A m.

The CAUSE OF DEATH* was as follows: (Acute Alcoholic Intoxication

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? — Findings

What test confirmed diagnosis?

(Signed) J. J. Yaruzal, M. D.

6 19 19 24 (Address) 29 S 11th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz cem.	June 20 1921
20 UNDERTAKER	ADDRESS
John Greblianckas	425 S. Paca St

Spest.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54680

CERTIFICATE OF DEATH.

64 D 54680

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 210 N Glover ST.: 6 WARD)

2-FULL NAME Thresia Stoller

(a) RESIDENCE. NO. 210 N Glover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 mos. ds. How long in U. S., if of foreign birth? 60 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 23rd 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	4.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carl Rot Bro
(Address) 210 N Glover St

15 JUN 20 1921 Registrar

Burial Permit Dist

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16 1921

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to June 16, 1921, that I last saw h alive on June 15, 1921, and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH was as follows:

[redacted] Asphyxia
Tuberculosis, Cerebral Hemorrhage

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs 1

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) F A Burnbaugh M. D.

6-17-21 (Address) 850 North Mt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL June 20 1921

20 UNDERTAKER M B Callender

ADDRESS Bank & Aisquith

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54681

D 54681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 40

CITY OF BALTIMORE: (No. 1379 N Gilmor ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida S. Wilkins

(a) RESIDENCE. No. 1379 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs — mos — ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X Widow X

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	41	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer American Wholesale Co. 69

9 BIRTHPLACE (city or town) (State or country) New-York.

PARENTS

10 NAME OF FATHER Theophilus Bestaly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Ida Adler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Emma Clarke
(Address) 1379 N. Gilmor St.

15 JUN 2 01921 Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 19, 1921, that I last saw h[er] alive on June 19, 1921 and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) yrs. 7 mos. da.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? "

What test confirmed diagnosis? none (Symptoms)

(Signed) John D. Queen, M. D.

19 21 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 21 1921
20 UNDERTAKER	ADDRESS
Martin Fahey's Sons	827 W. Pratt St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54682

CERTIFICATE OF DEATH.

18 D 54682

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1902 W. Pratt ST. 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Riehl

(Residence in Baltimore: No. 1902 W. Pratt St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow

6-DATE OF BIRTH: Not known, 1 (Month) (Day) (Year)

7-AGE: 64 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Not known

11-BIRTHPLACE OF FATHER (State or Country): Not known

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER (State or Country): Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward A Riehl Jr

(Address) 135 Mc Phail St

15- JUN 20 1921 ROBERT A KRAUTZ Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: June (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 17 1921, to June 19 1921, that I saw her alive on June 18 1921, and that death occurred, on the date stated above, at 430 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas of face, complicating Empyaema and Lower Lip

(Duration) ... yrs. about 4 ds.

CONTRIBUTORY (Secondary): None

(Duration) ... yrs. ... mos. ... ds.

(Signed) Henry C. Ash Jr. M. D.

June 19, 1921. (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: New Cathedral

DATE OF BURIAL: June 22, 1921

20-UNDERTAKER: Mc-Mechen & Sons Funeral

ADDRESS: 1835 W. Baltimore St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54683 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54683

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1722 Druid Hill Ave. ST., 40 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Cooper

(a) RESIDENCE. No. 1722 Druid Hill Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or WIFE of): late Stephen H. Cooper

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1858

7 AGE: Years 63; Months 4; Days 10; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ——— 000

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Bryson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Flora ———

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Oliver Cooper

(Address) 1722 Druid Hill

15 JUN 20 1921 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/16/1921

17

I HEREBY CERTIFY, That I attended deceased from 3/11/1921, to 6/16/1921, that I last saw h[illegible] alive on 6/16/1921, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) about 9 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? no Date of ———

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Tenbrook, M. D.

6/17/1921 (Address) 908 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: June 21 1921

20 UNDERTAKER: R C Frost

ADDRESS: 1495 McElderry

Important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54684

CERTIFICATE OF DEATH.

151 D 54684

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 McHenry ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Miles

(a) RESIDENCE. No. 905 McHenry ST. 21 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 9 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Fanny Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Guy E Miles

(Address) 905 McHenry St

15 JUN 20 1921

ROBERT I KRANTZ
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11 . 1921 . to June 18 . 1921 .

that I last saw him alive on June 18 . 1921 .

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth
7 mo Pregnancy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) General weakness

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jas E. Mrse, M. D.

1921 (Address) 1520 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 20th 1921
20 UNDERTAKER	ADDRESS
John J Cowan & Son	901 Hollins St

Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

Kutz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54685

CERTIFICATE OF DEATH.

29 D 54685

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305. S. Bond. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank. Kutz

(a) RESIDENCE. NO. 305 S. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Magdalena Kutz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Joseph Kuc

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Tomaszkiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Magdalena Kuc
(Address) 305 S. Bond

15 Filed JUN 20 1921 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2nd 1921, to June 17th 1921, that I last saw him alive on June 10th 1921, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Aortic and Mitral Regurg

(duration) Intermittent yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) A. F. Ries M. D.

June 20, 1921 (Address) 2 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	6/22 1921
UNDERTAKER Wm. Fallsworth	ADDRESS 618 Eastern Ave

Instructions on back of certificates. PART Statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54686

CERTIFICATE OF DEATH.

28 D 54686

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2015 Mc Henry (St.) 70 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor E. Schuring

(a) RESIDENCE. No. 2015 Mc Henry St.. Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. 9 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Earl J. Schuring

6 DATE OF BIRTH (month, day, and year): Sept 15 1903

7 AGE: Years 17 Months 9 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Rufus D. Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Sarah C[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Earl J. Schuring
(Address) 2015 Mc Henry

15 Filed JUN 20 1921 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1921, to June 18, 1921, that I last saw h[illegible] alive on June 17, 1921, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H W Jones, M. D.

, 19 (Address) Douglas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL 1921

UNDERTAKER: H B Kilpatrick — ADDRESS 223 Fremont Ave

Spec. instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54687

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54687

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Libsberg

(a) RESIDENCE. No. 1402 McHenry St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 6/10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Micheal Libsberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records,

(Address) New City Hospitals.

JUN 20 1921

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1921

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1921 to June 17, 1921.

that I last saw h im alive on June 16, 1921.

and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) R Herman, M. D.

6/17/21 (Address) New City Hospital:

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 20th 1921
20 UNDERTAKER	ADDRESS
H. Maurice Pentz	Gwynn Oak

Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54688

CERTIFICATE OF DEATH.

50

D 54688

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1236 S. Charles ST. 73 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Wilbur Alexander

(a) RESIDENCE. NO. 1236 S. Charles ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 45 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. G. Alexander

6 DATE OF BIRTH (month, day, and year): Dec. 9 1863

7 AGE — Years: 57 — Months: 6 — Days: 8 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): OD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Adams Co. Md.

PARENTS

10 NAME OF FATHER: Curtis B. Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country): Adams County Md.

12 MAIDEN NAME OF MOTHER: Elanor Kerr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Winchester, Va.

14 Informant: Mrs. Walsh

(Address): 1236 S. Charles St.

15 Filed JUN 20 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/17 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/11 1920. to 6/17 1921.

that I last saw her alive on 6/16/21 19 .....

and that death occurred, on the date stated above, at 6.20 a m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

Myocarditis

Dont Know (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis Left sided Hemiplegia. (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) J. Edward Norris M. D.

6/17 19 21 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Lorraine Cem	June 20 1921
20 UNDERTAKER: Margaret V. Flynn	ADDRESS: 1732 Light St.

Registrar

Burial Permit Clerk

Directions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54689

CERTIFICATE OF DEATH.

151 D 54689

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 Pennington Ave, St., Central Ave 25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dask

(a) RESIDENCE. No. 721 Pennington Ave St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 30 minutes ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) June 19 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	30 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ddd
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Louis Dask

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Louise Gelatis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mary Louise Gelatis
(Address) 721 Pennington Ave.

15 Filed JUN 20 1921 ROBERT J. BRAMBLE REGISTRAR
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1921

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1921, to June 19, 1921, that I last saw h[illegible] alive on June 19, 1921, and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth (3 mos.)
Had Lived in utero from birth. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lived 30 minutes. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) Harry Davis, M. D.

7/7 1921 (Address) 211 Lanvale St. Cor Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Co	June 20 1921
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St.

Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

19 8537 54690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54690

CERTIFICATE OF DEATH.

53

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marie Parker Sippel

(a) RESIDENCE. No. 3800 Greenmount ave ST., Balto Md WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female.	white	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of William F. Sippel

6 DATE OF BIRTH (month, day, and year) Sept 6. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	8	43	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Lawrence Parker

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Ida Collins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Hospital Records
(Address)

15 Filed JUN 21 1921 19.. ROBERT A. BAUTER
Registrar

N 201921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1921

17 May 13-21

I HEREBY CERTIFY, That I attended deceased from ~~April 20~~ May 13, 1921, to June 19, 1921, that I last saw h.er alive on June 19, 1921, and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myeloid Leukemia

(duration) 1 yrs. 2 mos. 12 ds.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 3-1921

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood Exam, Path. Diag. & Autopsy

(Signed) U R Mason, M. D.

6-19-21 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem

DATE OF BURIAL: June 21 1921

20 UNDERTAKER: John C. Middleton

ADDRESS: 120 W. Lafayette St.

Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54691

CERTIFICATE OF DEATH.

REGISTERED NO. 82

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE: (No. 119 E. West St.; Ward 21)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Davis.

(a) RESIDENCE. NO. 119 E. West St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, ~~Married, Widowed or Divorced (write the word)~~: Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1845

7 AGE — Years: 75 | Months: 9 | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): No occupation
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Amos N. Davis.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary Harris.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: James A. Tibbles
(Address) 376 Randall St

JUN 2 1921

Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 14 1921, to June 17 1921, that I last saw her alive on June 16 1921, and that death occurred, on the date stated above, at 3.50 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

about 5 yrs.
(duration)

CONTRIBUTORY (Secondary) Cerebral embolism
(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard D. Tolson, M. D.

, 19 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. | DATE OF BURIAL: June 20 1921

20 UNDERTAKER: F. A. Transfer Co | ADDRESS: 7037

See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54692

CERTIFICATE OF DEATH.

55 D 54692

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. St.: 23 Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles A. Beck

(Residence in Baltimore: No. 105 W. Henrietta St., St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. 7, 1863
(Month) (Day) (Year)

7-AGE, 37 yrs. 6 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Oil

9-BIRTHPLACE, (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Ernest M.

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Reed

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Beck

(Address) 105 W. Henrietta St

15- No. 201921, 191... ROBERT J. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 30, 1920 to June 1921, that I saw him alive on June 1921, and that death occurred, on the date stated above, at 6.15 P.m.

The CAUSE OF DEATH* was as follows:

Encephalitis lethargica

..... (Duration) 1 yrs. 3 mos. 17 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ruth E. Fairbanks M. D.

....., 191... (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 3 mos. 17 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?..... Balto. Md.

Former or usual residence Balto. Md.

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem.

DATE OF BURIAL, June 21, 1921

20-UNDERTAKER F. E. Francey & Son

ADDRESS 703 Hanover St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 54693

D 54693

1-PLACE OF DEATH. REGISTERED NO. C

CITY OF BALTIMORE: (No. 1503 Myrtle ave. St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Olonzo Wilson

(Residence in Baltimore: No. 1503 Myrtle ave. St.; 47 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Married

6-DATE OF BIRTH, January 12, 1874
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
47 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Waiter
(b) General nature of industry, business, or establishment in which employed (or employer). Hotel

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Henry Wilson

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Susan Pollard

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie Wilson (wife)

(Address) 1503 Myrtle ave.

15- ROBERT E KRAUTER

JUN 20 1921 191 Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 17, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from about April 20 1921, to June 17 1921, that I saw h is alive on June 16 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. 2 mos. ds.

not treated only 10 or 12 days

(Signed) L. F. Hammerbacher M. D.

June 17, 1921. (Address) 1524 Madison ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL. June 21, 1921

20-UNDERTAKER Edw. Ruggold — ADDRESS 1463 N. Carey St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mason.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54694

CERTIFICATE OF DEATH.

28 D 54694

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1319 Woody Eor ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel Mason

(a) RESIDENCE. NO. 1319 Woody Eor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48+ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Ann Mason

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 60+ — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 013

(b) General nature of industry, business, or establishment in which employed (or employer): Butcher

(c) Name of employer: Heitzmann & Schmidt

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: John Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Fetter Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Alice Ann Mason 1319 Woody Eor

15 Filed JUN 20 1921 ROBERT I. GRAFTON Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1921, to June 17, 1921, that I last saw h— alive on June 14, 1921, and that death occurred, on the date stated above, at 9:15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Hepatis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Second Stage Arteriosclerosis (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1319 Woody Eor

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Walter W. Wright, M. D.

June 18, 1921 (Address) 1209 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: June 20 1921

20 UNDERTAKER: Edw. Ruggold — ADDRESS: 1463 Carey

Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54695

CERTIFICATE OF DEATH.

120 D 54695

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 20 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mueller

(a) RESIDENCE. No. Wilkins Ave & Bentley Lane ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margreth Mueller

6 DATE OF BIRTH (month, day, and year) July 25-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conderein Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kimpmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margreth Mueller (Address) Wilkins & Bentley Lane

15 JUN 20 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1921

17 I HEREBY CERTIFY, That I attended deceased from June 9 . 1921 . to June 19 . 1921 . that I last saw h alive on June 19 . 1921 . and that death occurred, on the date stated above, at 6 00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis X. Kenny, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 22 1921
20 UNDERTAKER	ADDRESS
Wendelken Uffelman & Son	373 Pac

See instructions on back of certificates. Should state property classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks. Pinpano Zinpaco

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 45278
B 54696

CERTIFICATE OF DEATH.

92 D 54696

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pasquale Pinpano

(a) RESIDENCE. No. 906 Fawn St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11- 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michell Pinpano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Rosa Conetto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant J. H. Hospital Records
(Address)

15 JUN 20 1921 ROBERT I. TRAVERS Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1921, to June 18, 1921, that I last saw him alive on June 18, 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

a Primary Pneumonia

b

c

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Impetigo

(duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis M. D.

6-19-21 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 20 1921

20 UNDERTAKER Wendell Dyffel & Son ADDRESS 878 Mo

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54697

CERTIFICATE OF DEATH.

28 D 54697

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1756 Fremont Av ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Joseph Schaufele

(a) RESIDENCE. No. 1756 Fremont Av ST., WARD.
(Usual place of abode) (If nonresident give City or town and State)

Length of residence in city or town where death occurred 28 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Alice E Schaufele

6 DATE OF BIRTH (month, day, and year) January 28th 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse shoer

(b) General nature of Industry, business, or establishment In which employed (or employer) 036

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Adolph Schaufele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kaufman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Alice E. Schaufele
(Address) 1756 Fremont Ave

15 Filed JUN 20 1921 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 17th, 1921, to June 18th, 1921, that I last saw h[illegible] alive on June 18th, 1921, and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum exam.

(Signed) [illegible] M. D.

6/19/21 (Address) 1016 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 21 1921
20 UNDERTAKER	ADDRESS
Henry Horch Son	1301 E Eager

Directions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54698

D 54698

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Harford Road near Berwick ave. ST.: 27 WARD)

2-FULL NAME Mary Margaret Budde.

(a) RESIDENCE. NO. Harford Road near Berwick ave. ST., 27 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16th 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Music Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John V. Budde.

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Bernadina Thomae

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Anna M. Arendt.
(Address) Harford Rd. near Berwick Ave

15 FILED JUN 20 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from July ... 1917, to June 15 ... 1921, that I last saw h... alive on June 15th ... 1921, and that death occurred, on the date stated above, at 12 10 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 22 mos. ds.

18 Where was disease contracted, if not at place of death? U. S. A. Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms, T.B.

(Signed) Dr. J. E. Ziegler, M. D.

, 19 (Address) Gibbons Ave + Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 21st 1921

20 UNDERTAKER Lilly + Zeiler

ADDRESS 4003 Wash Ave

Spec.—1-10-21 M&T 1500 Bks.

D 54699

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

D 54699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West end maternity

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Boice

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1921

7 AGE	Years	Months	Days	If LESS than 1 day 10 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West end mty Balto.

PARENTS

10 NAME OF FATHER Jenty Boice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kingston N.Y.

12 MAIDEN NAME OF MOTHER Ada Tompkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Purchase N.Y.

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 JUN 20 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to June 17, 1921, that I last saw her alive on June 16, 1921, and that death occurred, on the date stated above, at 8.10 A m.

The CAUSE OF DEATH* was as follows:

Two months premature

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Imperfect respiration & heat radiation (duration) ..... yrs. ..... mos. 10 hrs.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Benson Purcell Mason M. D.

6/17 1921 (Address) 103 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL JUN 21 1921

20 UNDERTAKER ..... ADDRESS .....

Commissioner Health,
Per Wm F NOODALE

Exact statement of OCCUPATION on back of certificates.

D 54700

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 54700

120

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3612 Roland Ave. ST. V3 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME E. Milton Booker

(Residence in Baltimore: No. 3612 Roland Ave. St. 33 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Aug. (Month) 31 (Day), 1863 (Year)

7 AGE: 57 yrs. 9 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9 BIRTHPLACE (State or country): Carroll Co. Md.

PARENTS

10 NAME OF FATHER: Jesse Booker

11 BIRTHPLACE OF FATHER (State or country): Carroll Co. Md

12 MAIDEN NAME OF MOTHER: Julia Miller

13 BIRTHPLACE OF MOTHER (State or country): Carroll Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Florence T. Booker

(Address) 3612 Roland Ave.

15 Robert P. Harrison,

Filed ..... 191 ..... Burial Permit Clerk. REGISTRAR

(1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 19th (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. - 1920 to June 19 1921.

that I saw h im alive on June 18th 1921.

and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Mitral Regurgitation Aortic Insufficiency (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Chronic Interstitial Nephritis (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry C. Algire M. D.

June 19, 1921 (Address) 3645 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St. Mary's (Hampden)

DATE OF BURIAL: June 21, 1921

20 UNDERTAKER: Horace F. Burgee

ADDRESS: 363 Falls Rd

See instructions on back of certificate. Items must be filled in EXACTLY. PHYSICIANS should state if occupation may be properly classified. Exact statement of OCCUPATION

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 54701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54701

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2811 Clifton Ave ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie S. Cook

(a) RESIDENCE. No. 2811 Clifton Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced (write~~ the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 4, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	7	15	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) Wash Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Larkin S. Cook.

11 BIRTHPLACE OF FATHER (city or town) Wash Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Eliza J. Martin

13 BIRTHPLACE OF MOTHER (city or town) Wash Co
(State or country) Md.

14 Informant Harry A. Cook
(Address) 2014 Longwood St

15 1921 Robert P. Harrison, 19
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16th, 1921, to June 19th, 1921, that I last saw her alive on June 19th, 1921, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. S. Jones M. D.

, 19 (Address) 720 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 21, 21
20 UNDERTAKER George J. Smith	ADDRESS 1000 25 Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

D 54702 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54702

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1310 Hull St.; 24 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Watson

(Residence in Baltimore: No. 1310 Hull St.; St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	

6-DATE OF BIRTH, June 3, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry W. Watson

11-BIRTHPLACE OF FATHER (State or Country), York City Pa.

12-MAIDEN NAME OF MOTHER Mary Coyhan

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry W. Watson

(Address) 1310 Hull St.

15-

Filed ....., 191.... Robert P. Harrison,
Registrar.

201921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1921, to June 20 1921, that I saw him alive on June 19 191.., and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

1. Ileo. colitis

.....

.....

..... (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) S. x. Laurelton Maryland

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) T. O'Leonard M. D.

June ..., 1921 (Address) 322 E. Fort ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Cross Cemetery	June 21, 1921
20-UNDERTAKER	ADDRESS
Margaret F. Flynn	1111 Light St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54703

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

D 54703

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 437 N Robinson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adelaide Margaret Lemmon

(Residence in Baltimore: No. 437 N Robinson St. 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	white	Single

6-DATE OF BIRTH. May 11, 1921
(Month) (Day) (Year)

7-AGE. ....yrs. 1 mos. 9 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE. (State or Country). Baltimore,

PARENTS.

10-NAME OF FATHER. Morgan Hamilton Lemmon

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Irene Kelly

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Irene Lemmon

(Address) 437 N. Robinson St

15- Filed JUN 21 1921 191... Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 20, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1921, to June 20 1921, that I saw her alive on June 20 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 7 ds.

(Signed) Adolph Ta Emmons M. D.

June 20, 1921 (Address) 227 N. Carrollton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park — DATE OF BURIAL. June 24, 191...

20-UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54704

CERTIFICATE OF DEATH.

H 2 D 54704

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mattson

(a) RESIDENCE. No. 642 S. 14th St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Finland

PARENTS

10 NAME OF FATHER: Jack Alakanto

11 BIRTHPLACE OF FATHER (city or town) (State or country): Finland

12 MAIDEN NAME OF MOTHER: Hilnea Kumpsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Finland

14 Informant: Hospital Records, (Address) New City Hospitals.

15 Filed JUN 21 1921 ROBERT J. KAUFFER Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1921, to June 19, 1921, that I last saw her alive on June 19, 1921, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia

Cachexia (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) F. A. Holden, M. D.

6/20/1921 (Address) New City Hospital.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet DATE OF BURIAL: June 22 1921

20 UNDERTAKER: W. E. Edelen & Bro. ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54705

CERTIFICATE OF DEATH.

176 D 54705

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 Druid Hill Ave ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE. NO. 415 Druid Hill Ave ST., WARD.

(Usual place of abode) 35 35

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wid. Cornelia A. Smith

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Matilda Ellis (Address) 415 Druid Hill Ave

15 Filed JUN 21 1921 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921. to June 18, 1921. that I last saw h[illegible] alive on June 17, 1921. and that death occurred, on the date stated above, at 11:20 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia (duration) 8 days

CONTRIBUTORY (Secondary) Cystitis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Robinson M. D.

6/18 1921 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	June 21 1921
20 UNDERTAKER Sam'l Hensley	ADDRESS Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54706

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 D 54706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1722 Webster ST.; 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua T. Bunch Jr.

(a) RESIDENCE. NO. 1722 Webster ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of or WIFE of: Virginia Bunch

6 DATE OF BIRTH (month, day, and year): July 9, 1840

7 AGE — Years: 80 — Months: 11 — Days: 9

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Mariner

(b) General nature of industry, business, or establishment in which employed (or employer): Capt of Steam Vessel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Joshua Bunch Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Henrietta LaBar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Virginia Bunch 1722 Webster St

15 Filed JUN 21 1921 ROBERT I. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 19, 1921, that I last saw him alive on June 19, 1921, and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary): Senility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Physical signs.

(Signed) Sidney H. Thuett, M. D.

6/20 1924 Address) 40 St Paul St Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	June 22 1921
20 UNDERTAKER	ADDRESS
Mrs. E. Evans	1428 Lbard St

D 54707

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

139 D 54707

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore Hospital ST. 23 WARD)

2 FULL NAME Wilhemina Margaret Landt

(Residence in Baltimore: No. 7 W. Heath St. St.: 25 yrs. 4 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: July 8th (Month) (Day), 1896 (Year)

7 AGE: 25 yrs. 4 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Domestic 037
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo. M. Schaumloffel

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Teresa Schmelzle

13 BIRTHPLACE OF MOTHER (State or country): Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Christian Landt

(Address) 7 W. Heath St

15 JUN 21 1921 Filed ....., 191 ROBERT S. BRUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 17 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1921, to June 17th 1921, that I saw h[illegible] alive on June 17th 1921, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Collapse after birth of Child - probably from heart trouble

(Duration) yrs. mos. 2 hours ds

Contributory (SECONDARY) Confinement

(Duration) yrs. mos. ds.

(Signed) Jerome H. Byrne M. D.

June 20th 1921 (Address) 1223 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Olivet Cem DATE OF BURIAL: June 22 1921

20 UNDERTAKER: Mrs L E Evans & Son ADDRESS: 1220 E Chase

1-20

D 54707

PHYSICIANS should properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54708

CERTIFICATE OF DEATH.

64 D 54708

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hosp. (Street) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cath. E. Hagerty

(a) RESIDENCE. NO. 1036 N. Eden St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Servant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	mod.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Servant. 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph H.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant Mr. Joseph Hagerty

(Address) 1036 N. Eden St.

15 JUN 21 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19 1921

17

I HEREBY CERTIFY, That I attended deceased from 6-18 1921, to 6-19 1921, that I last saw h[illegible] alive on 6-19 1921, and that death occurred, on the date stated above, at 2:50 a.m.

The CAUSE OF DEATH* was as follows:

1. Cerebral hemorrhage

OVER

— (duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dudley P. Bowie, M. D.

(Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cem.	6/21/21 19

20 UNDERTAKER H. C. Wedefind

ADDRESS

Important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history other than child complained of pain one day & the next had rt side paralysis.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54709 ✓ D 54709

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH Alston Apartments REGISTERED NO. C

CITY OF BALTIMORE: (No. 32nd & N. Charles ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Jane Hildebrand

(Residence in Baltimore: No. 32nd & N. Charles St.; 69 yrs. 9 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, Feb 2 1861 (Month) (Day) (Year)

7-AGE, 59 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——— 800
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John H. Gilpin

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary J. Gilpin

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Gilpin

(Address) Alston Apartments

15- JUN 21 1921 191... BOYER & KRAUTER Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1921, to June 18 1921, that I saw her alive on June 18 1921, and that death occurred, on the date stated above, at 8.20 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis & dilatations

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) yrs. mos. ds.

(Signed) Benj. F. Pilliod M. D.

June 20, 1921. (Address) 1929 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
LOUDON PARK	JUN 21 1921

20-UNDERTAKER	ADDRESS
JOHN F. DENNY	716 LIGHT ST.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54710

CERTIFICATE OF DEATH.

D 54710

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 N. Pat. Pk. Ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Ziegler

(a) RESIDENCE. NO. 423 N. Pat. Pk. Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? 75 yrs. 4 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of late Geo. H. Ziegler

6 DATE OF BIRTH (month, day, and year) Jan 30-46

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER James H. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nancy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry E. Hedeman

(Address) 423 N. Pat. Pk. Ave

15 JUN 21 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17th, 1919, to June 17th, 1921, that I last saw h[illegible] alive on June 17th, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis complicated by broken compensation of Right heart due to myocardial insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? Physical Examination

(Signed) Amelia V. Zimmerman M. D.

, 19 (Address) 1805 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk	June 21 1921

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54711

CERTIFICATE OF DEATH.

120-091 D 54711

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 N Gay ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Shanley

(a) RESIDENCE. No. 1125 N Gay ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 50

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Christopher H Shanley

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ann Mellen

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Christian Shanley
(Address) 1125 N. Gay St

15 Filed JUN 21 1921 19 ROBERT I. KRAETZER Registrar
Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to June 20 1921, that I last saw him alive on June 20 1921, and that death occurred, on the date stated above, at 1/2 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis - Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis etc

(Signed) A. L. Donaldson M. D.

(Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	June 23 1921
20 UNDERTAKER	ADDRESS
Robt J Timmer	1xx N Bway

Spec.—8-24-14—M. & T.—2000 Bks.

D 54712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 54712

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1718 McCulloh St. 14 (WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph K. Brayton

(Residence in Baltimore: No. 1718 McCulloh St.; 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1856
(Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter 070
(b) General nature of industry, business, or establishment in which employed (or employer) Futhie

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (State or Country), Don't know

12-MAIDEN NAME OF MOTHER Don't know

13-BIRTHPLACE OF MOTHER (State or Country), Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard A. Brown

(Address) 1403 McCulloh St

JUN 21 1921

Filed....., 191.....

BOWEN & KRAUTER

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19th, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7th 1921, to June 19th 1921, that I saw h[illegible] alive on June 19th 1921, and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows: Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Arterio Sclerosis

(Duration) 2 yrs. mos. ds.

(Signed) A. Lee Ellis M. D.

6-23-21, 191.. (Address) 624 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Cem. DATE OF BURIAL, June 22, 1921

20-UNDERTAKER David Carton ADDRESS 916 E

(Over)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54713

CERTIFICATE OF DEATH

37 D 54713

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Lawrence

(a) RESIDENCE. No. 195 Third ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lobster 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bay View Hospital Balto, Md.

15 Filed JUN 21 1921 ROBERT P. LEGUEN Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1921

17

I HEREBY CERTIFY, That I attended deceased from May 21, 1921, to June 20, 1921, that I last saw him alive on June 19, 1921, and that death occurred, on the date stated above, at 4.00 m.

The CAUSE OF DEATH* was as follows:

General Paralysis (7th Stage)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Cirrhosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Serological

(Signed) H. Goldsmith M. D.

6/22/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 22 1921
20 UNDERTAKER	ADDRESS
A. Sander & Sons	1710 Flat St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54714 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

43 D 54714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3109 Foster Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Louise Bullock.

(a) RESIDENCE. No. 3109 Foster Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Bullock

6 DATE OF BIRTH (month, day, and year) Jan. 27-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sarah Marsden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John Bullock

(Address) 3109 Foster Ave.

Filed JUN 21 1921 ROBERT I. KRAETZER Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13th 1921, to June 19th 1921, that I last saw her alive on June 19th 1921, and that death occurred, on the date stated above, at 1. 30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Left Breast

(duration) 1 yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? .....

(Signed) H. C. Schwatka, M. D.

6-20 1921 (Address) 734 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Cemetery	June 22 1921
20 UNDERTAKER	ADDRESS
H. Vanderford Sons	1710 Ft. Ave.

Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54715

CERTIFICATE OF DEATH.

105 D 54715

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2711 Riggs ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME [redacted] Kearns

(a) RESIDENCE. NO. 2711 Riggs ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Timothy Kearns

6 DATE OF BIRTH (month, day, and year): not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	about 81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 000

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Manion

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mary Gavan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. L. Manning
(Address): 2711 Riggs ave

15 Filed JUN 21 1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1921 to June 20th 1921.

that I last saw h or alive on June 17th 1921.

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Enteritis, Chronic

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) Walter E Kearney, M. D.

19 (Address) 1013 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 22 1921
20 UNDERTAKER: James Di'gnan & Son	ADDRESS: 1000 S Paca St

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54716

D 54716

CERTIFICATE OF DEATH.

109

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Albert Crawbeth

(a) RESIDENCE. NO. 762 Penna Ave ST. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of Mrs. Margaret Crawbeth

6 DATE OF BIRTH (month, day, and year) Mch. 24, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 632

(b) General nature of industry, business, or establishment in which employed (or employer) City Fire Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Crawbeth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Margaret Crawbeth
(Address) 762 Penna Ave

15 Filed JUN 21 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10th 1921 to June 19 1921 that I last saw him alive on June 19 1921 and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Operation for Hernia June 11, '21,
Pulmonary Embolism June 19, '21,
5 min - Asphyxia - 2 min -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism 5 min -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 11, 1921

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs —

(Signed) W. F. Martin - , M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 22 1921
20 UNDERTAKER	ADDRESS
James D. Lyman & Son	800 S. Paca St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54717

CERTIFICATE OF DEATH.

79 D 54717

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2451 McCulloh St.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie B Matthews

(Residence in Baltimore: No. 2451 McCulloh St. St.; 36 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.): Married

6-DATE OF BIRTH, Oct 3 (Month) (Day), 1885 (Year)

7-AGE, 38 yrs. 9 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Martinsville Va

PARENTS.

10-NAME OF FATHER, Allen Fountain

11-BIRTHPLACE OF FATHER (State or Country), Martinsville Va

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), Martinsville Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Damon G. J. Matthews

(Address) 2451 McCulloh St

15- Filed JUN 21 1921 191... ROBERT J. KNAUER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 1921, to June 18 1921, that I saw h[illegible] alive on June 17 1921, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. 1 mos. ds.

(Signed) Charles J. Blake M. D.

June 20, 1921 (Address) 20 E. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem't	June 21 1921
20-UNDERTAKER	ADDRESS
Theodore G White	113 Walbert

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54718 CERTIFICATE OF DEATH. 4 79 D 54718

1-PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital, Bay View WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hazel [illegible]

(a) RESIDENCE. No. 619 Cider Alley ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Tom Hazel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JUN 21 1921 ROBERT E. LAZZELL Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1921 to June 17, 1921, that I last saw him alive on June 16, 1921, and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes No.

What test confirmed diagnosis? No special test

(Signed) B Bateman, M. D.

Address) New City Hospital. 6/17/1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	
20 UNDERTAKER	ADDRESS
Commissioner Health.	JUN 21 1921

D 54719

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54719

CERTIFICATE OF DEATH.

104

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 606 Comb Alley. ST. 27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Leona Harris.(C). -- -- 3 -- 23.

(Residence in Baltimore: No. 606 Comb Alley. St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH, February 28th, 1921. / (Month) (Day) (Year)

7-AGE. -- yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Andrew Harris.(C).

11-BIRTHPLACE OF FATHER (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER Winnie Dixon.(C).

13-BIRTHPLACE OF MOTHER (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Winnie Harris.(C).(mother).

(Address) 606 Comb Alley.

15- ROBERT J KRAUTER

JUN 21 1921. 16- Burial Permit Given Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea and Enteritis.

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ... (Duration) ...yrs. ...mos. ...ds.

(Signed) ... M. D. (Coroner.)

June 21st, 1921. (Address) 1017 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Mt Auburn et	June 21, 1921.
20-UNDERTAKER	ADDRESS
J. L. Bramble Son	[illegible]

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 54720

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Miller

(a) RESIDENCE. No. 208 W. Cross St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

040

9 BIRTHPLACE (city or town) (State or country): Anna Arundel Co., Maryland

PARENTS

10 NAME OF FATHER: Benjamin Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anna Arundel Maryland

12 MAIDEN NAME OF MOTHER: Sarah Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anna Arundel Co. Maryland

14 Informant: Hospital Records.

(Address): New City Hospital

15 Filed JUN 21 1921

ROBERT J. KRAUTER Registrar of Vital Statistics

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1921, to June 19, 1921, that I last saw him alive on June 18, 1921, and that death occurred, on the date stated above, at 2:45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopic test

(Signed) J. Ettenman M. D.

6/20/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct — DATE OF BURIAL: June 22 1921

20 UNDERTAKER: J. L. Broumell Son — ADDRESS: 108 W. Monte

Sections on back of certificates. Exact statement of OCCUPA- ... State

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54721

D 54721

98

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1703 Harman Alley ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie Grace Whitfield.

(a) RESIDENCE. No. 1703 Harman Alley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	M.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis H Whitfield

6 DATE OF BIRTH (month, day, and year) Feb 17 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lewis H. Whitfield

(Address) 1703 Harman Alley

15 JUN 21 1921 ROBERT I. CARTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921, to Jan 20, 1921, that I last saw h[illegible] alive on Jan 20, 1921, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Strauss, M. D.

6/20 1924 (Address) 409 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Jun. 24 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Pratt

Sec. 6 of Act requires that all certificates be properly classified. Exact statement of OCCUPATIONS should state the instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(See affadavit over)

D 54722

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54722

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH Joseph Norman Pencil

CITY OF BALTIMORE: (No. 850 Ramsey ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Joseph D Loane Jr~~

(a) RESIDENCE. NO. 850 Ramsey ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs 10 mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) Aug 21st 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

600

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph D Loane Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Walsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Jos D Loane Jr

(Address) 850 Ramsey St

15 JUN 21 1921 BOBERT I. DAUTER Registrar

Burial ... Disp.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1921

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to June 20, 1921, that I last saw him alive on June 20, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw V Cockeluen M. D.

6/21 1921 (Address) 1111 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL June 22 1921

20 UNDERTAKER John J Cowan & Son

ADDRESS 901 Walker

(See back of certificates, for statement of OCCUPA-

State of Maryland
City of Baltimore SS

Personally appeared before me Dr Ed. F.
Corcoran to me personally known who
duly sworn, says, and deposes that the
death reported by him on June 20/
of Joseph A Toano Jr. ~~was~~ was an
error. and was not Joseph. A Toano
but Joseph Toman Penal the latter bei
the correct name of the deceased.
Sworn and subscribed to this
day of July 1921

Sam Greenber
Notary Pub

Dr. Edward Corcoran
24 N. Fulton Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54723

HEALTH DEPARTMENT—CITY OF BALTIMORE

39-091 D 54723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~William P. Reymer~~ or William V. Roehner.

(a) RESIDENCE. No. Unknown ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Christian ~~Reymer~~ Roehner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Mary Gerholt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Hospital Records,

(Address) New City Hospital.

Filed JUN 21 1921 ROBERT J. KNOTTS Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to June 18, 1921, that I last saw him alive on June 18, 1921, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. A. Holden, M. D.

6/20/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 22nd 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54724

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54724

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 813 N. Broadway (St.:) 7 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob. Vinson.

(a) RESIDENCE. (No.) 813 N. Broadway (St.,) (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. Vinson

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76.	8	5.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician - 131

(b) General nature of Industry, business, or establishment in which employed (or employer) "

(c) Name of employer Retired.

9 BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER Jacob. D. Vinson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. C. Vinson.

(Address) 813 N. Broadway.

Filed ... 19...

6 21 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16 1921, to June 20, 1921, that I last saw him alive on June 19, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

MBV

A Nephritis

(duration) ... yrs. ... mos. 5 ds.

Coma.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallis W White Jr. M. D.

6/20 1921 (Address) 2800 St Paul st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery.	June 22 1921
20 UNDERTAKER	ADDRESS
L. Heemann.	32 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54725

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54725

CERTIFICATE OF DEATH.

x 64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1830 E. North Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Conart Cof

(a) RESIDENCE. No. 1830 E North Ave ST.. WARD. Conart Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Octavious H. Cof

6 DATE OF BIRTH (month, day, and year) Sept 24 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm Conart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Letitia Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Mr Routt Conart Va

Filed 1 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17

I HEREBY CERTIFY, That I attended deceased from May 9 - 1921, to June 21, 1921, that I last saw h[illegible] alive on June 21, 1921, and that death occurred, on the date stated above, at 7-30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) E. Gill Hall M. D.

June 21 1921 (Address) 1617 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Conart Va	June 22 1921
20 UNDERTAKER	ADDRESS
Hand & Sondheim	1120 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54726

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54726

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 346 N Entrance ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kwedar

(a) RESIDENCE. NO. 346 N Entrance ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 21

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(h) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. City
(State or country)

PARENTS

10 NAME OF FATHER Joseph Kwedar

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Morton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Jos Kwedar
(Address) 346 N Entrance Ave

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to June 20, 1921, that I last saw h[illegible] alive on June 20, 1921, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Atelectasis
(duration) yrs. mos. 6 ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Jas. L. Hooper, M. D.

6-21-1921 (Address) 346 E. 20th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	6/22/21
20 UNDERTAKER Geo. J. Kirby	ADDRESS 1735 Harford Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54727

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54727

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 Laurens ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Forbes

(a) RESIDENCE. NO. 1832 Fairmount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 28-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 141

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Forbes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A. Co Md

12 MAIDEN NAME OF MOTHER Lizzie Forbes

13 BIRTHPLACE OF MOTHER (city or town) A.A. Co Md (State or country)

14 Informant Mattie Holland (Address) 1832 Laurens

15 Filed JUN 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1921

17

I HEREBY CERTIFY, That I attended deceased from May 24th 1921, to June 19 1921, that I last saw h[illegible] alive on June 19 1921, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Heinitz M.D.

June 19 21 (Address) 1313 W South St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 22 1921
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 Carey St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history.

Spec.—8-24-14—M. & T.—2000 Blks.

D 54728 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54728

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 4105 Liberty Heights Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Elizabeth Kirk Coles

(Residence in Baltimore: No. 4105 Liberty Heights Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 3, 1876 (Month) (Day) (Year)

7-AGE, 44 yrs. 11 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chief Clerk Auto 009
(b) General nature of industry, business, or establishment in which employed (or employer): Federal Reserve Bank

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Spillman Coles

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md

12-MAIDEN NAME OF MOTHER Sophia O'Lewis

13-BIRTHPLACE OF MOTHER (State or Country) London England

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) E K Cullen

(Address) Near Howard Hotel

Filed....., 191.... Robert P. Harrison, Registrar.

2 1 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH June 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 9 - 1921, to June 20 1921, that I saw her alive on June 19 1921, and that death occurred, on the date stated above, at 5-30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Mitral Insufficiency

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

(Signed) E. K. Schilling M. D.

June 20, 1921 (Address) 4107 Liberty Hgts.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park — DATE OF BURIAL, June 22 1921.

20-UNDERTAKER — ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

D 54729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54729

CERTIFICATE OF DEATH.

X 37,091

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Phipps Clinic Johns Hopkins Hosp ST.; W. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles D Harris

(Residence in Baltimore: No. York Pa St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Married

6-DATE OF BIRTH, October (Month) 18 (Day) 1889. (Year)

7-AGE, 31 yrs. 4 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor 080
(b) General nature of industry, business, or establishment in which employed (or employer): Clothing

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Joseph F. Harris

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Hobbs

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John P. Holman

(Address) Johns Hopkins Hosp

Filed Robert P. Harrison, 191

1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1921, to June 2 1921, that I saw him alive on June 2 1921, and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane
(Dementia Paralytica)

(Duration) yrs. 2½ mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 2 ds.

(Signed) John P. Holman M. D.

June 2, 1921. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 8 ds. In the State yrs. mos. 8 ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence 450 W Market st York Pa

19-PLACE OF BURIAL OR REMOVAL, Westminster Md. DATE OF BURIAL, June 23, 1921.

20-UNDERTAKER W. Maurice Rowland ADDRESS York Pa

Remarks

Luetic infection

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*	
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*	
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*	
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*	

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Anna Ehrman)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54730

D 54730

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1438 Hull (St.) 24 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Ehrman

(a) RESIDENCE. NO. 1438 Hull ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced (HUSBAND) (or) WIFE of: Thomas Ehrman

6 DATE OF BIRTH (month, day, and year): April 27. 1901

7 AGE — Years: 20 — Months: 1 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: own) Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Austria - Hungary

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria - Hungary

12 MAIDEN NAME OF MOTHER: Rosie Schlanker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria - Hungary

11 Informant: Thos. Ehrman.

(Address): 1438 Hull st

Filed: Robert P. Harrison, Registrar

1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1921. to June 20. 1921.

That I last saw h[illegible] alive on June 20. 1921.

and that death occurred, on the date stated above, at 10:20 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. J. Marx M. D.

6.20. 1921 (Address) 827 S. Eaton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. — DATE OF BURIAL: June 23 1921

20 UNDERTAKER: W. J. Tuckner & Sons — ADDRESS: North & Penna Ave

D 54731 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 116 E. Ostend Street. ST. 24 WARD) REGISTERED No. C 182

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary T. Gehring. 52 -- 10 -- 4.

(Residence in Baltimore: No. 116 E. Ostend Street. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow.

6-DATE OF BIRTH, August 15th, 1868. (Month) (Day) 1 (Year)

7-AGE. 52 yrs. 10 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None. 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Francis X. Dauer.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Theresa M. Dinkle.

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonard C. Gehring. (son).

(Address) 132 E. Gitting Street.

15- June 21 1921 Robert P. Harrison, 191 Registrar.

Burial Permit Cert.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19th, 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage and laceration of the brain due to a pistol shot wound in the head. Homicide. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Wm. H. Reinhardt M. D. (Coroner.)

June 21st, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Cross, Dale DATE OF BURIAL, 6-22, 1921

20-UNDERTAKER C. B. Hale ADDRESS 115 E. West St

Statement of OCCUPATION is very

D 54732 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54732

1-PLACE OF DEATH — REGISTERED No. C 175-005

CITY OF BALTIMORE (No. Mercy Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Mercer

(Residence in Baltimore: No. ~~Md~~ Waterville Md. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown, ... (Month) (Day) (Year)

7-AGE, 29 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER Lucinda Mercer

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record

(Address)

15- Robert P. Harrison,

Filed JUN 21 1921, 191 Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, an~~ ~~autopsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Amputation of Left Leg above Shock & Hemorrhage

(Duration) yrs. a few hours mos. ds.

CONTRIBUTORY (Secondary) Ren's Dr by Dr & R.R. Train

(Duration) yrs. mos. ds.

(Signed) H. F. Gruenigh M. D. (Coroner.)

6-21, 1921 (Address) 117 N. Paca St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Watersville Md	6-22 1921
20-UNDERTAKER	ADDRESS
E & J Hasle	N & E Ave & 8th

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 54733

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54733

CERTIFICATE OF DEATH.

X 143

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise A. Crisp

(a) RESIDENCE. NO. Stevenson Rd. ST., ... WARD. Stevenson Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 18 ds. How long in U. S., if of foreign birth? 18 yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A Crisp

6 DATE OF BIRTH (month, day, and year) July 26 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John A. Crisp
(Address) Stevenson Balto Co Md

15 JUN 22 1921 ROBT. J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17

I HEREBY CERTIFY, That I attended deceased from June 3 . 1921 . to June 21 . 1921

that I last saw h e alive on June 21 . 1921

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Scalp.

FIRST

(duration) ..... yrs. ..... mos. 30 ds.

CONTRIBUTORY (Secondary) Brain Abscess

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? At residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pus from scalp.

(Signed) M. D. Tolson Pumphrey M. D

, 19 (Address) Maryland Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Thomas Cemetery	June 23 1921
20 UNDERTAKER J. F. Eline	ADDRESS Reisterstown Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Had small pimple on top of head which developed into furuncle. Cellulitis due to above & abscess outcome of cellulitis

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 54734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54734

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 N. Castle St ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hepple

(a) RESIDENCE. No. 614 N. Castle ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Hepple

6 DATE OF BIRTH (month, day, and year) Jan 17, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... mln.
	64	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer) Gunther Bldg

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katie Hepple (Address) 614 N. Castle St

15 JUN 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1921, to June 20, 1921, that I last saw h... alive on June 20, 1921, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar 2nd 1921

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) F. W. Holdenreich, M. D.

, 19 (Address) 32+33 Gunther Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: June 23, 1921

20 UNDERTAKER: Henry Lutz — ADDRESS: 1007 N. Bond

SOLOMON I. BAUER
Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54735

64D 54735

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1115 Warner ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phoebe Robb.

(a) RESIDENCE. No. 1115 Warner ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
~~HUSBAND OF~~ (or) WIFE of Richmond Robb

6 DATE OF BIRTH (month, day, and year) 1851 (about)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
70(?)		(?)	(?)	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Essex County Virginia

PARENTS

10 NAME OF FATHER Wm Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co. Va.

12 MAIDEN NAME OF MOTHER Caroline (maiden name unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex Co Va.

14 Informant Moses Robb. (Address) 1115 Warner St.

15 Filed JUN 22 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15th, 1921, to June 20, 1921, that I last saw h er alive on June 19th, 1921, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Arterial Hypertension

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Daniel H. Lamell, M. D.

6/21, 1921 (Address) 1400 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	June 23 1921

20 UNDERTAKER J. L. Broadus Son

ADDRESS 616 W Monty

Spec.—8-24-14—M. & T.—2000 Bks.

D 54736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 D 54736

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 246 Bowers Ct. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME alice Mc. Conrad

(Residence in Baltimore: No. 246 Bowers Ct. St.; 4yr yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, ... Jan (Month) 29 (Day), 1921 (Year)

7-AGE, ... yrs. 4 mos. 23 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Wm H. Mc. Conrad

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rebecca Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Conrad

(Address) 246 Bowers Court

15- ROBERT J. REUTER

JUN 22 1921 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14 1921, to June 21 1921, that I saw h er alive on Jun 21 1921 and that death occurred, on the date stated above, at 6.45 a m.

The CAUSE OF DEATH* was as follows:

W Coughing Cough

..... (Duration) ..... yrs. ..... mos. 7 ..... ds.

CONTRIBUTORY (Secondary) Convulsions

..... (Duration) ..... yrs. ..... mos. 4 hours ds.

(Signed) H E Kunkel M. D.

June 21, 1921. (Address) 1102 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. [redacted] mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, June 22, 1921

20-UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

Spec.--6-9-19—H. P. Co.—1000 Bks.

148906
D 54737

HEALTH DEPARTMENT—CITY OF BALTIMORE

8,091 D 54737

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (ST.:) 6 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Burton.

(a) RESIDENCE. No. 2022 E. Fairmount Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Hannah Burton (Mother)

6 DATE OF BIRTH (month, day, and year) April 22, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 005

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Walter Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah Kaufholz.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant (Address) Johns Hopkins Hospital. Records

JUN 22 1921 BOYCE J. REUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to June 21, 1921, that I last saw him alive on June 21, 1921, and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ....yrs. ....mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Horton Caspares, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oheb Shalom	June 22 1921
20 UNDERTAKER	ADDRESS
Joseph Abrus	221 N Bway

Spec.—1-10-21—M&T—1500 Bks.

D 54738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 54738

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3701 Eastern ave. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Guercio

(a) RESIDENCE NO. 3701 Eastern ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 28-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	1	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Anthony Guercio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Annie Anorano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Francis Guercio (Address) 3701 Eastern ave

15 FILED JUN 22 1921 [illegible] Registrar

Burial Form 1 Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to June 21, 1921, that I last saw h— alive on June 21 1921 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Coma

Pneumonia (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Called Dr Thompson Dr Lee Dr [illegible] 2nd time Dr [illegible] (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

June 22, 1921 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cemetery	6/22 1921
20 UNDERTAKER J. A. Moran	ADDRESS 300 E Baltimore

Form. —6-9-19—H. P. Co.— 1000 Bks.

D54739

HEALTH DEPARTMENT—CITY OF BALTIMORE

D54739

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1018 Lexdenhall St. 23 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Boyd

(a) RESIDENCE. NO. 1018 Lexdenhall St. 23 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Eella Boyd

6 DATE OF BIRTH (month, day, and year) Mar 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 23

(b) General nature of industry, business, or establishment in which employed (or employer) Coal driver

(c) Name of employer W. J. Chapman & Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant (Address) Mrs Edward Boyd 1018 Lexdenhall St

Filed JUN 23 1921 [redacted] Registrar

Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20/1921

17 I HEREBY CERTIFY, That I attended deceased from 6/16/1921, to 6/20/1921, that I last saw h[illegible] alive on 6/20/1921, and that death occurred, on the date stated above at 10-15 P m.

The CAUSE OF DEATH* was as follows:

Uremia Coma

(duration yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arrio Parenchymatous Nephritis (duration about 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Ernest Bowles, M. D.

6/21/1921 (Address) 908 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 23 1921
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Eutaw

D 54740

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 D 54740

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2201 Barclay St. St. V2 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George T. Brice

(Residence in Baltimore: No. 2201 Barclay St. St.: 68 yrs. 10 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: August 18, 1852 (Month) (Day) (Year)

7 AGE: 68 yrs. 10 mos. 3 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
Retired (none) 000

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: W

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Anna C. Brice (daughter)

(Address) 2201 Barclay St.

15 JUN 22 1921

ROBERT I KRAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 21, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 21 1921, that I saw h-m alive on June 20, 1921, and that death occurred, on the date stated above, at 10.30 ~~P. M.~~ A. M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis myocarditis.
Chronic interstitial Nephritis

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) Acute dilitation of Heart

(Duration) yrs. mos. 4 ds.

(Signed) W.S. Nibbitt M. D.

June 21, 1921. (Address) 2220 Garrison Ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemty

DATE OF BURIAL: June 23, 1921.

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

PHYSICIANS should be properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 54741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 54741

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 39 W Preston St. ST., 11 WARD)

2-FULL NAME Marilouise Waters

(a) RESIDENCE NO. 39 W. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 18-1921

7 AGE: Years | Months | Days: 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Chas Wesley Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Margaret Kefel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 Informant (Address): Chas. Wesley Waters 39 W. Preston St. M.D.

15 Filed: JUN 22 1921 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1921, to June 22, 1921, that I last saw h[illegible] alive on June 21, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar) OVER

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical course.

(Signed) Harry S. McCarty, M. D.

6 22, 1921 (Address) 37 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: June 22 1921

20 UNDERTAKER: Harris W Ehlen

ADDRESS: W. North Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other infection.
Perfectly healthy baby.

Rjwe.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54742

CERTIFICATE OF DEATH.

K 91 D 54742

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division St., 14 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Sauers

(a) RESIDENCE. No. Randallstown Md. WARD. Randallstown Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. 18 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4 - 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— 000

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Howard W. Sauers

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Margaret K. Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant John R. Arthur & Son

(Address) Forks Maryland

15 Filed JUN 22 1921 19 ROBERT E [illegible] Registrar

Bureau Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1921, to June 21, 1921, that I last saw her alive on June 21, 1921, and that death occurred, on the date stated above, at 5.20 p.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) ___ yrs. ___ mos. 27 ds.

CONTRIBUTORY (Secondary) ———

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ———

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. A. Blackford, M. D.

(Address) Union Memorial Hospital 6/22/19 21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baldwin Md	June 23 1921

20 UNDERTAKER William Cook ADDRESS 502 E North Ave

Spec.—4-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54743

CERTIFICATE OF DEATH.

28-B 91 54743

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emmanuel Latchford

(a) RESIDENCE. No. 2012 Bel Air ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Francis Latchford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Margaret Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records
(Address) M. T. H.

15 JUN 22 1921 ROBERT J. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1921, to June 20, 1921, that I last saw him alive on June 20, 1921, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Broncho Pneumonia (duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) M. Ketchey M. D.

6-21-21 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 24 1921

20 UNDERTAKER William Cook ADDRESS 502 E North

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54744

CERTIFICATE OF DEATH.

104

D 54744

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1727 Barclay ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Lee Hong Chong

(a) RESIDENCE. No. 1727 Barclay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Chinese

5 Single, Married, Widowed, or Divorced (write the word): Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12 1920

7 AGE — Years: — Months: 7 Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Hon Chong

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Ann Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): China

14 Informant: Hon Lip
(Address) 1724 Barclay

15 Filed . 19 ROBERT F. KRUG Registrar

JUN 22 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1921, to June 21, 1921, that I last saw her alive on June 21, 1921 and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Probably Food.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W K Gorsuch M. D.

6/22 1921 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Lim — DATE OF BURIAL: June 23 1921

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Mott

Keep this certificate clean. PHYSICIANS—Please write plainly. Every item is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH should be made. Avoid use of abbreviations. Use black ink. Do not write across face of certificate.

D 54745 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54745

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 175-063

CITY OF BALTIMORE (No. on Freight Car on B&OR.R. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Saml C. Beat-

(Residence in Baltimore: No. 1248 Riverside Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
M	W	Married

6-DATE OF BIRTH, ——— (Month) — (Day) 1871 (Year)

7-AGE, 49 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brake man 073
(b) General nature of industry, business, or establishment in which employed (or employer): B & O R.R.

9-BIRTHPLACE, (State or Country): Va

PARENTS.

10-NAME OF FATHER, UNknown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Beat

(Address) 1248 Riverside Ave

15- Filed JUN 22 1921, 191 [redacted] J FAHEY Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull & Shock Thereof while on Top of Freight Car on B & O R.R.

(Duration) a few minutes

CONTRIBUTORY (Secondary) Accident (Duration) yrs. mos. ds.

(Signed) W K Gorsuch M. D. (Coroner.)

6-21, 1921 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem.	6/23/21, 19
20-UNDERTAKER	ADDRESS
John J Fahey & Sons	1318 Light St

D 54746

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54746

CERTIFICATE OF DEATH.

153

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital St. or Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harold Jones

(Residence in Baltimore: No. 848 Hampden St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col	Boy

6-DATE OF BIRTH, Dec 1 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.... Boy
(b) General nature of industry, business, or establishment in which employed (or employer)....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Cuba

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JUN 22 1921 ROBERT J. KRAUSE Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lock Jaw

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) L. Kerr Snader, M. D.
(Coroner.)

6-22-21, 191.. (Address) 1426 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 19
20-UNDERTAKER	ADDRESS
Commissioner Health,	JUN 22 1921

W. W. P. WOODALL

18264

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 54747

1-PLACE OF DEATH West End Maternity

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Kunce.

(a) RESIDENCE NO. West End Maternity ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day ... hrs or ... min.
—	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) West End Maternity Balto.
(State or country)

PARENTS

10 NAME OF FATHER Mrs Samuel Kunce

11 BIRTHPLACE OF FATHER (city or town) Switzerland
(State or country)

12 MAIDEN NAME OF MOTHER Martha Richter

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant
(Address)

15 Rec'd JUN 22 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to June 21, 1921,
that I last saw h— alive on June 20, 1921,
and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6/21, 1921 (Address) 517 East St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL JUN 22 1921

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

JOHN F. WOODALL.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54748

CERTIFICATE OF DEATH.

28 D 54748

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1018 Brentwood Ave. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Leo Steinmeier

(a) RESIDENCE No. 1018 Brentwood Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Sharp & Dohm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Geo E Steinmeier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary L. Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Marie Steinmeier
(Address) 1018 Brentwood Ave

Filed JUN 22 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20-21 19

17

I HEREBY CERTIFY, That I attended deceased from 6/1/20 19 , to 6/20/21 19 ,

that I last saw him alive on 6/19/21 19 ,

and that death occurred, on the date stated above, at 1158 m.

The CAUSE OF DEATH* was as follows:

Pt Phthisis Pulmonalis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Answered

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) F. H Herrman, M. D.

(Address) 2014 E. Baltimore 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	6/23/21
20 UNDERTAKER	ADDRESS
A. C. Windsor	414 Gunter

Spec—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54749

CERTIFICATE OF DEATH.

81 VD 54749

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 Willow St. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Parick J. Smith

(a) RESIDENCE. NO. 823 Willow St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Smith

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retirod

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs Mary E. M. Laughlin 217 E Biddle St

15 Filed JUN 22 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 20, 1921, that I last saw h[illegible] alive on June 20, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

I never attended him before

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 829 Willow St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

(Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	6/24 1921
20 UNDERTAKER	ADDRESS
C.F.Evans & Son	118 W. Mt Royal Ave

Duplicate statement of OCCUPA-

Duplicate certificates.

D 54750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

175-801 ✓ D 54750

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. W. Josh Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L. Crem

(Residence in Baltimore: No. 1616 E. Preston St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Wh.	Married

6-DATE OF BIRTH, June 21, 1857
(Month) (Day) (Year)

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: 073
(a) Trade, profession, or particular kind of work, Custodian
(b) General nature of industry, business, or establishment in which employed (or employer) P. R. R.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry H. Crem

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Margaret Shuttleworth

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lida J. Crem

(Address) 1616 E. Preston

15- JUN 22 1921 191... ROBERT J. KRAUSE Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Left Leg

Date (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Wade Frazier M. D.
(Coroner)

June 24, 1921 (Address) 16 E. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Greenmount Cemetery DATE OF BURIAL, June 23 1921

20-UNDERTAKER Robt. J. Krause & Bro ADDRESS 1442 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54751 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54751

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital, Bay View St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Vlach

(a) RESIDENCE. No. 1610 N. Guilford Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 680

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

10 NAME OF FATHER Michael Vlach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

PARENTS

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921. to June 20, 1921. that I last saw him alive on June 20, 1921. and that death occurred, on the date stated above, at 11:30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) B. Herman, M. D.

6/20/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	June 23 1921
20 UNDERTAKER	ADDRESS
Frank Brack Son	1906 Gorsuch Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D 54752 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54752

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 745 Bradley ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Chase

(Residence in Baltimore: No. 745 Bradley St.; 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. Oct (Month) 17 (Day) 1873 (Year)

7-AGE. 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House Work
(b) General nature of industry, business, or establishment in which employed (or employer). Home

9-BIRTHPLACE, (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, James Gray

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jane Moore

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Gray

(Address) 745 Bradley St

15- Filed ..., 191... Robert P. Harrison, Registrar.

2192 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 20 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1921, to June 20 1921, that I saw h er alive on June 20 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

Acute

(Duration) Mos. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John E Stanard M. D.

, 191... (Address) 1304 W. LAFAYETTE AVE

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, June 23. 1921.

20-UNDERTAKER R E Gross — ADDRESS 1405 McElderry St

Spec.—8-24-14—M. & T.—2000 Bks.

D 54753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54753

CERTIFICATE OF DEATH.

104

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 Garrison Lane ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Flack

(Residence in Baltimore: No. 17 Garrison Lane St.; ..... yrs., 5 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... Jan (Month) 13 (Day), 1921 (Year).

7-AGE, ... yrs. 5 mos. 9 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Flack

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ana Brown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Anna Flack

(Address) ..... 17 Garrison Lane

Robert P. Harrison,

Filed ....., 191.....

2, 1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 22 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from June 19 1921, to June 22 1921, that I saw h.. alive on June 21 1921, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

..... (a) Malignant Endocarditis

.....

..... (Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

June 22, 1921. (Address) 601 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park	June 23 1921.
20-UNDERTAKER	ADDRESS 319 Fred. Ave.
C. H. Dill	

Spec.—8-24-14—M. & T.—2000 Bks.

(Sullivan)

D 54754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54754

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 323 ½ Carey St. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Elizabeth Sullivan

(Residence in Baltimore: No. 323 ½ Carey St. St.; 67 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Oct (Month) 8 (Day), 1853 (Year)

7-AGE: 67 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Dennis Sullivan

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Elizabeth Victory

13-BIRTHPLACE OF MOTHER (State or Country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosie M. Brewer

(Address) 323 N Carey St

Filed ....Robert P. Harrison.... Registrar.

2 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: June (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1921, to June 20 1921, that I saw h.. alive on June 19 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

..... (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Epithelioma Pelvis

..... (Duration) yrs. mos. ds.

(Signed) J. T. Chesney M. D.

6/22, 1921. (Address) 504 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: June 23, 1921

20-UNDERTAKER: John C. Mitchell — ADDRESS 1201 W. Fayette

D 54755 HEALTH DEPARTMENT—CITY OF BALTIMORE 119 D 54755

CERTIFICATE OF DEATH.

(PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 22 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leon Feldhuman,

(Residence in Baltimore: No. 507 E. Green St. St.; 15 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 21, 1898
(Month) (Day) (Year)

7-AGE, 23 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer 640
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER, Sol. J. Feldman

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary Opher

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Feldhuman

(Address) 507 E. Green St

15-

Filed 2 1921

Robert F. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest~~ autopsy or inquiry thereon and from the evidence obtained by said ~~Inquest~~, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis & Congestion of Lungs

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) don't know

(Duration) yrs. mos. ds.

(Signed) H. K. Gorman M. D.
(Coroner.)

6-22 1921 (Address) 117 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Milton Whf. Md DATE OF BURIAL, June 23 1921

20-UNDERTAKER John H. Tradine ADDRESS 142 Uxbridge St

Spec.—6-9-19—H. P. Co.—1000 Bks.

14 8771 D 54756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54756

CERTIFICATE OF DEATH.

X 29

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luther Huffman.

(a) RESIDENCE. No. Longo, W. Va ST.. WARD. Garmon W. Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married

3a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE of~~ Henry Payne (Father-in-law) Hinton

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer. 086

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Solomon Huffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Elizabeth Bland.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant (Address) Johns. Hopkins Hospital Record

15 [illegible] 27 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11 1921, to June 22, 1921, that I last saw him alive on June 22, 1921, and that death occurred, on the date stated above, at 9.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Generalized)

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? Hinnicks, West Va.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. R. Mason, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harmon Cemetery Co W Va	6/23/1921

UNDERTAKER ADDRESS

H. E. Hughes 4 nt St. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54757

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54757

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. North Broadway St.: 6 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Cordia Wilkinson

(a) RESIDENCE. No. Newton, N. C., St.. Ward. Newton N. C.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of T. Milton Wilkinson

6 DATE OF BIRTH (month, day, and year) January 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Michael Keener.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Harriet Fry.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Thomas M. Wilkinson
(Address) Newton, N. C.

15 Filed Robert P. Harrison, Registrar
1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1921, to June 22, 1921.

That I last saw her alive on June 22, 1921.

and that death occurred, on the date stated above, at 6:10 P m.

The CAUSE OF DEATH* was as follows:

Surgical Shock

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Psoas abscess and Osteo-myelitis - Right Hip duration yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Exploratory of Right Hip.

Did an operation precede death? Yes Date of June 22, 1921

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) W. M. Noble M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[redacted] Catawba Co N. C.	6/22 19 21

20 UNDERTAKER H. E. Hughes ADDRESS 414 N. Broadway.

D 54758 HEALTH DEPARTMENT--CITY OF BALTIMORE D 54758

CERTIFICATE OF DEATH

64

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 2002 Guilford Ave. ST. 17 WARD)

(If death occured i a hospital or institution give its NAME instead o street and number an fill out No. 18.)

2 FULL NAME Wm Wilson Blake

(Residence in Baltimore: No. 2002 Guilford Ave. St.: Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Dec 18, 1860 (Month) (Day) (Year)

7 AGE: 60 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Statistician 186
(b) General nature of industry, business, or establishment in which employed (or employer): American RR Ass,

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm. Blake

11 BIRTHPLACE OF FATHER (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Maria Smith

13 BIRTHPLACE OF MOTHER (State or country): Catonsville Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs W W Blake

(Address) 2002 Guilford Ave

15 Filed 2 2 1921

Robert P. Harrison, 191 (Burial Permit Clerk) REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 21, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to June 21 1921

that I saw him alive on June 21, 1921

and that death occurred, on the date stated above, at 4.15 P m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) yrs. mos. 7 d

Contributory (SECONDARY) Arterio-Sclerosis & Chron Bright's Disease (Duration) 5 yrs. mos. d

(Signed) Marshall B Hurst M.

June 21, 1921. (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. d

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: June 23, 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E North

Use instructions on back of certificate. PHYSICIANS should ... properly classified. Exact statement of OCCUPATION ... may be pro...

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54759

CERTIFICATE OF DEATH.

79 ✓ D 54759

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 N. Gilmor St. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel P. Zernick.

(a) RESIDENCE. No. 1033 N. Gilmor St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Widow

3a If married, widowed, or divorced (HUSBAND) of (or) WIFE of J. Frederick Zernick.

6 DATE OF BIRTH (month, day, and year) Dec 9-1831.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89.	6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home NNN

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James A. Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Charity Disney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura Stephens

(Address) 1033 N. Gilmore

15 Filed ..... 19 Robert P. Harrison, Registrar

1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1921, to June 21, 1921, that I last saw her alive on June 21, 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia ofdump

(duration) V yrs. X mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam

(Signed) Lloyd Talbot, M. D.

June 21, 1921 (Address) 1353 W Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 25 1921

20 UNDERTAKER ADDRESS

Lowbook & Son E. North

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54760

CERTIFICATE OF DEATH.

64 D 54760

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antone Wagner

(a) RESIDENCE. No. None ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 04

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

Informant Hospital Records,
(Address) New City Hospitals.

Filed JUN 23 1921 [illegible] Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1921

17 I HEREBY CERTIFY, That I attended deceased from August 21, 1916, to June 18, 1921

that I last saw him alive on June 17, 1921.

and that death occurred, on the date stated above, at 9:05 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical test.

(Signed) Patterman, M. D.

6/18/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	June 22 1921

20 UNDERTAKER MRS. N. S. FINK, FUNERAL DIRECTORS 1935 W. PRATT STREET. ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54761

CERTIFICATE OF DEATH.

120 D 54761

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Genral Hospital St.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank R Perry

(a) RESIDENCE. NO. 5108 Reisterstown Rd ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced (write~~ the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23rd 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	-	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Soldier. - 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Henry L. Harvey

(Address) 5108 Reisterstown Rd.

Filed JUN 23 1921 19.. ROBERT I. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22/21

17 I HEREBY CERTIFY, That I attended deceased from 6/14/21, 19.., to 6/22/21, 19.., that I last saw him alive on 6/22/21, 19.., and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Analysis

(Signed) Esterbur Lewis M. D.

6/22/1921 (Address) Md. Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M.D. National Cemetery	May 24th 21
20 UNDERTAKER	ADDRESS
Putnam & Gore	1723 N. Eutaw St

D 54762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54762

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 4 WARD) REGISTERED NO. C 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Norman Spencer

(Residence in Baltimore: No. 320 N Pine St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	colored	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
16 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer 140
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Wm Spencer

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Nellie Spencer

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Easton

(Address) 916 Pa ave

15- Filed JUN 23 1921, 191... ROBERT J. CRAWFORD Registrar

Burial Permit Oliver

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquiry~~) thereon and from the evidence obtained by said ..... (Inquest, autopsy ~~or inquiry~~.) did that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound upper Chest, Left Side accidentally by Milton Gilbert

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Gorman M. D.
(Coroner.)

6-23, 1921 (Address) 117 N. Paca St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	June 24, 1921
20-UNDERTAKER David Easton	ADDRESS 916 Pa ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54763

CERTIFICATE OF DEATH.

34

D 54763

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital, Bay View) ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Stewart

(a) RESIDENCE. NO. 763 Dover St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Thomas Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Lynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records,
(Address) New City Hospital.

Filed JUN 23 1921 ROBERT J. KRAFFT Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 1, 19 21, to June 21, 19 21

that I last saw her alive on June 20, 19 21

and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Tubercular Salpingitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tubercular Peritonitis (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) F A Holden, M. D.

6/21/19 21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 26 19 21
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa Ave

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54764

28 D 54764

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 S. Calhoun St.: 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edward Cummings

(a) RESIDENCE. No. 118 S. Calhoun St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 20-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John T. Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Annie V. Francomano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant (Address) John T. Cummings Father 1185 Calhoun St

Filed JUN 23 1921 ROBERT I. KRAUSER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/21 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1920, to June 20, 1921, that I last saw him alive on June 20, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? ✓ Date of

Was there an autopsy? none

What test confirmed diagnosis? clinical & Path.

(Signed) Wallace Cummings, M. D.

6/21, 1921 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 24 1921
20 UNDERTAKER	ADDRESS
Robert A Brookson	CALHOUN HOLLINS STS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54765

CERTIFICATE OF DEATH.

91 D 54765

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3427 O. Donnell ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward W. Hoffman

(a) RESIDENCE. NO. 3427 O. Donnell ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child ppp

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank A. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Vorinaca Ahrens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

Informant Vorinica Hoffman
(Address) 3427 O. Donnell St.

JUN 23 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20 , 1921 , to June 22nd , 1921 , that I last saw him alive on June 21st , 1921 , and that death occurred, on the date stated above, at 3 15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia 0737

(duration) yrs. mos. 4 ds.

~~CONTRIBUTORY~~ ~~(Secondary)~~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. W. Jones , M. D.

6/22 1921 (Address) 1013 N. Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	June 23 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	4033 E. Monument

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy." "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54766

91 D 54766

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maried A. Mitchell

(a) RESIDENCE. NO. 1733 Eager St ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1 - 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ///

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William E. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Bahr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mary Mitchell (Address) 1733 Eager St

15 Filed JUN 23 1921, 19 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1921, to June 21, 1921, that I last saw her alive on June 21, 1921, and that death occurred, on the date stated above, at 11 50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia Bronchial

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

6/21, 1921 (Signed) Frank C. Marcine, M. D. (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	June 23 1921
20 UNDERTAKER Lilly and Zeile	ADDRESS 403 E. Monument

HEALTH DEPARTMENT—CITY OF BALTIMORE

119 D 54767

CERTIFICATE OF DEATH.

119 D 54767

REGISTERED NO C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 437 W. Biddle St. 11 WARD)

If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lauzo Bonner

(Residence in Baltimore: No. 437 W. Biddle St - St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (If *write* the word.) Single

6-DATE OF BIRTH, November, 1898
(Month) (Day) (Year)

7-AGE, 23 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 841

9-BIRTHPLACE, (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER. Henry Bonner

11-BIRTHPLACE OF FATHER (State or Country). N. Carolina

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norman Walby

(Address) 422 S. Charles St

15-

Filed JUN 23 1921 ROBERT J. KRAUTER

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death (by or through) on the day stated above.

The CAUSE OF DEATH* was as follows: (To be ascertained by microscopical examination. (Pending).

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Office)

June 22 1921 (Address) 2102 Eutaw Place.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cemetery

DATE OF BURIAL. 6/23, 1921

20-UNDERTAKER. Wm. H. Hoffberger

ADDRESS 406 W. Lanvale St

Acute nephritis. As further history.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage*,	*Meningitis*,	*Phlebitis*,
Cellulitis,	*Gangrene*,	*Miscarriage*,	*Pyæmia*,
Childbirth,	*Gastritis*,	*Necrosis*,	*Septicæmia*,
Convulsions,	*Erysipelas*,	*Peritonitis*,	*Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54768

CERTIFICATE OF DEATH.

H 2 D 54768

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 E. Preston ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth E. Bull

(Residence in Baltimore: No. 1013 E. Preston St. 59 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 5, 1882 (Month) (Day) (Year)

7-AGE, 39 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nurse
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Reilly

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Frances Collins

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wicks

(Address) 1303 Ensor

JUN 23 1921

Filed....., 191.. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1920, to June 22 1921, that I saw h[illegible] alive on June 22 1921, and that death occurred, on the date stated above, at 3:40 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast and thyroid gland

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis with

(Duration) yrs. 3 mos. ds.

(Signed) [illegible] M. D.

6/22/21, 191.., (Address) 1613 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery DATE OF BURIAL, June 25, 1921.

20-UNDERTAKER Henry Lutz ADDRESS 1007 N. Bond

Spec.—6-9-19—H. P. Co.—1000 Bka.

D 54769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

115 D 54769

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary P. Beatty

(a) RESIDENCE. NO. 262 W. Hoffman ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 29 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore ~~Md~~ Maryland

PARENTS

10 NAME OF FATHER: Cornelius C. Beatty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Margaret Rue

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs Edward J. Stapleton

(Address) 2518 Maryland ave

15 Filed JUN 23 1921 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1921, to June 21, 1921, that I last saw her alive on June 21, 1921, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. cholecystitis

(duration) 3 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) — yrs. — mos. 1 da

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 23 1921
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North ave

Exact statement of OCCUPA-

Date of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54770

CERTIFICATE OF DEATH.

103 D 54770

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2117 St. Paul St.: 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Birkey

(a) RESIDENCE. No. 2117 St. Paul St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~~Widow~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER Thomas Hughes Birkey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Marie Ann E. Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant (Address) Miss Mary V. Sappington, 2117 St. Paul Street

15 FILED JUN 23 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1921, to June 21st, 1921, that I last saw her alive on June 21st, 1921, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Abcess in the walls of the abdomen as far as we know beginning about the 21st of March.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Advanced years

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Rupture of abcess

(Signed) John J Pennington, M. D.

19 (Address) 1826 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	6/23 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Spec.—8-24-14—M. & T.—2000 Bks.

D 54771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

165 D 54771

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital St. 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Noble A. Anderson

(Residence in Baltimore: No. 2505 Roslyn Ave St. ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... Oct (Month) 3rd (Day) 1878 (Year)

7-AGE, 42 yrs. 8 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Factory .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Yarns .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Richard Anderson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Anderson

(Address) 2505 Dougter Ave

15- Filed JUN 23 1921, 191.. BOYER & KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 21st (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14 1921, to June 21st 1921, that I saw h.m alive on June 21st 1921, and that death occurred, on the date stated above, at 10.10 P. m.

The CAUSE OF DEATH* was as follows:

..... Duodenal Ulcer .....

.....

..... (Duration) Mos. yrs. — mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal perforation Operation

..... (Duration) — yrs. ..... mos. ..... ds.

(Signed) Steuart F. Steelman M. D.

June 22, 1921 (Address) 122 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Lorraine	June 24, 1921

20-UNDERTAKER	ADDRESS
Jones Bros	W. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54772

30 D 54772

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 Linkaue St. Ruxton WARD)

2-FULL NAME Sylvia F. Spahn

(a) RESIDENCE. NO. 26 Linkaue ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Overlea

PARENTS

10 NAME OF FATHER Geo. F. Spahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary E. Hessler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Geo F Spahn 26 Linkaue

15 Filed JUN 23 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Obtd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 21, 1921.

that I last saw h[illegible]live on June 20 1921

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion - T Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) T. B. Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Pressure

(Signed) Chas Dumm, M. D.

(Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Solicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 23 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

(1) Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54773

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54773

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kozojet

3a (a) RESIDENCE. No. 953 Washington St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JUN 23 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921. to June 22. 1921. that I last saw her alive on June 21. 1921. and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis. (No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile deterioration

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) [illegible], M. D.

6/22/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 24 1921
20 UNDERTAKER Fiokler & Fiokler	ADDRESS 1739 Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54774 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54774

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 213 Richmond ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian M. Wagner -

(a) RESIDENCE. No. 213 Richmond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 65 mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col -	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Jan 8 — 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Allen W Wagner -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Harriet Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Allen W Wagner Father

(Address) 213 Richmond St -

15 JUN 23 1921 ROBERT I KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1921, to June 22, 1921, that I last saw her alive on June 22, 1921, and that death occurred, on the date stated above, at 11 55 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions - OVER

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Indigestion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Stools & Observation

(Signed) Samuel A Bain, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Auburn Cem	June 24 1921
20 UNDERTAKER George H Holland	ADDRESS 163 Robert St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Intestinal Indigestion

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54775

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54775

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2134 E. Dolphin St.; 8 WARD)

2-FULL NAME James L. Bordley

(a) RESIDENCE. No. 2134 E. Dolphin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced
HUSBAND of Sarah L. Bowers
~~or, WIFE of~~

6 DATE OF BIRTH (month, day, and year) — — 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) Grocer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. H. Bordley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah L. Bordley
(Address) 2134 E. Dolphin St.

15 Filed JUN 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to June 20, 1921, that I last saw h— alive on June 19, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Colitis

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. Cheatham, M. D.

6/22 1921 (Address) 5101 Loudon Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 6/23 1921

UNDERTAKER H. Hildebrand — ADDRESS 1318 Eutaw St

Deputy Registrar

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54776

CERTIFICATE OF DEATH.

D 54776

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Nettie Warner —

(a) RESIDENCE. NO. 18 E Lanvale St WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Rev George R Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER R. A Hopwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md.

14 Informant C. Hopwell Warner

(Address) 18 E Lanvale St

15 Filed JUN 23 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 9 . 1920. to June 22 . 1921.

that I last saw her alive on June 22 . 1921.

and that death occurred, on the date stated above, at 7:40 P m.

The CAUSE OF DEATH* was as follows:

Mammal Carcinomatosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Wm Wahle, M. D.

. 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St James P.E. Cem. Monkton	6-24 1921
20 UNDERTAKER Henry A Jenkins & Sons Co	ADDRESS McCulloh & Chase

Check statement of OCCUPA- ... of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

involved
First organ unknown

Spec—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54777

CERTIFICATE OF DEATH.

-8-091 D 54777

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Josephine Gervase

(a) RESIDENCE: No. 398 Forrest St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 22 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Gennardo Gervase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Matilda De Prima

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

PARENTS

14 Informant Hospital Record
(Address)

15 Filed JUN 23 1921 Burial Permit [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to June 22, 1921, that I last saw h[illegible] alive on June 22, 1921, and that death occurred, on the date stated above, at 9 20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebrosis

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X ray

(Signed) W P Carlson, M. D.

, 19 (Address) 714

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent's Cem	6/23/21
20 UNDERTAKER	ADDRESS
Geo J Kuth	125 Hanover

Upson—8-9-19—B. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54778

CERTIFICATE OF DEATH.

104 D 54778

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2443 E. Preston ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy E. Copenhaver

(a) RESIDENCE. No. 2443 E. Preston ST., 8 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 27 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm E Copenhaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carrollton Md.

12 MAIDEN NAME OF MOTHER Cora E. Bachmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carrollton Md

14 Informant Cora E Copenhafer
(Address) 2443 E Preston St

15 Filed JUN 23 1921 ROBERT F. FRAUTEN Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1921, to June 21, 1921, that I last saw her alive on June 21, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. J. Hergy Md. M. D.

6/22 1921 (Address) 130 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Silver Run. Md.	6-24 1921
20 UNDERTAKER E and B Hale	ADDRESS 145 E Lexington

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 D 54779

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1527 Baldwin (St.) 13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Carey

(a) RESIDENCE. No. 1527 Baldwin St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Marrird

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis Carey

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	55.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Howard Co. Maryland.

PARENTS

10 NAME OF FATHER: Unk Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Josephine Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Mary Edson. (Address) 1527 Baldwin St

15 Filed 2 3 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 21 1921, to June 21 21 1921, that I last saw h[illegible] alive on June 21 21 1921, and that death occurred, on the date stated above, at 9.25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus Bladder & Rectum

(duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary): Anemia & Uremia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What lest confirmed diagnosis? No

(Signed) P. A. Lillich M. D.

(Address) 1527 Union St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. Md.

DATE OF BURIAL: 6/24 1921

20 UNDERTAKER: Unsworth & Son.

ADDRESS: 367 Edmondson Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54780

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH Little Sisters

CITY OF BALTIMORE: (No. Institute of Mer. Prot. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Murphy

(a) RESIDENCE. NO. Preston & Valley Alley ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Florence (Address) Preston & Valley

15 Filed 1921 Robert P. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from No record, 19 , to , 19 ,

that I last saw h im alive on June 19 , 1921,

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

June 23 (Signed) F. A. Warner, M. D.

1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 24 1921
20 UNDERTAKER	ADDRESS
J. C. Windfield	914 Gremmy Ave

Exact statement of CCDPA.

certificates.

D 54781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1306 Upton St. ST. 17 WARD)

REGISTERED No. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Wright

(Residence in Baltimore: No. 1306 Upton St. St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widower

6-DATE OF BIRTH, ... Unknown ....., 1879
(Month) (Day) (Year)

7-AGE, ... 42 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION,
(a) Trade, profession, or particular kind of work ..... Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) 070

9-BIRTHPLACE, (State or Country), California

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Blake

(Address) 1306 Upton St

15- Robert P. Harrison,

Filed ....., 191 .....

23192 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June 21 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Hennessy M. D.
(Coroner)

June 22 1921 (Address) 201 E. Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, ... DATE OF BURIAL, ..., 19....

20-UNDERTAKER ..... ADDRESS .....

UNIVERSITY OF MARYLAND
Commissioner Health,
APR 23 1921

D 54782 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54782

CERTIFICATE OF DEATH.

25 175 008

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Stmr. Potomac Pier 2 Light ST. St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilbur Wimbish.(C)

(Residence in Baltimore: No. 31- 7th.St.Fairfield. St.; yrs., 16 mos. ------- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, January 21st. 1885., 1 (Month) (Day) (Year)

7-AGE, 36 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Steamboat. (C)
(b) General nature of industry, business, or establishment in which employed (or employer)..... Fireman.

9-BIRTHPLACE, (State or Country), North Carolina.

PARENTS.

10-NAME OF FATHER, Robert Wimbish.(C)

11-BIRTHPLACE OF FATHER (State or Country), North Carolina.

12-MAIDEN NAME OF MOTHER Millie Henderson.(C)

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Wimbish.(C)father.

(Address) 31- 7th St.Fairfield.

15- Robert P. Harrison,

Filed ....., 191.....

N23192 Burial Permit Clerk. Registrar.

morgue

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 15th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally struck on the head by a piston of an engine.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto Leonhardt M. D. (Coroner.)

June 16., 1921 (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL, JUN 23 1921, 19....

20-UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health.

Per. Wm. E. WOODALL

D 54783 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54783

CERTIFICATE OF DEATH.

1 PLACE OF DEATH — REGISTERED No. C 119

CITY OF BALTIMORE (No. University Hospital ST.: 19 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Walter Hunt

(Residence in Baltimore: No. 221 N Parish St. St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ... Don't Know, ... (Month) (Day) (Year)

7-AGE, ... 22 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Jno Hunt

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lizzie Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Hall

(Address) R 21 N. Parish St

15-

Filed ..... 1921 Robert F. Harrigon, Registrar.

231921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan 21, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquiry~~.) thereon and from the evidence obtained by said ..... (Inquest, autopsy ~~or inquiry~~.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis & Congestion of Lungs

(Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Forsyth M. D. (Coroner.)

6-1-23., 1924. (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. Mt Auburn — DATE OF BURIAL. Jan 24, 1921

20-UNDERTAKER Brown & Pickard — ADDRESS 1114 W Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54784

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54784

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sanford Williams

(a) RESIDENCE. No. 715 N. Dallas St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed 3 1921 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1921

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1918, to June 21, 1921, that I last saw him alive on June 20, 1921, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia, thrombotic

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V. K. Herman, M. D.

6/21/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Falls Church Va	Jun 24 1921
20 UNDERTAKER	ADDRESS
Nelson Davis	315 N Eden St

...Should State ... Exact statement of OCCUPA- ... back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 54785

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54785

CERTIFICATE OF DEATH.

69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7621 Greenmount ave ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ray Peterson

(Residence in Baltimore: No. 7621 Greenmount ave St.; 15 yrs., / mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~ Single (Write the word.)

6-DATE OF BIRTH, June 3 / 1889
(Month) (Day) (Year)

7-AGE, 32 yrs. 4 mos. 18 ds.

If LESS than 1 day, ~~hrs. or~~ ~~min.~~

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Philadelphia Pa

PARENTS.

10-NAME OF FATHER, Frank J. Peterson

11-BIRTHPLACE OF FATHER (State or Country). Kansas Co Md

12-MAIDEN NAME OF MOTHER Martha L. Bentz

13-BIRTHPLACE OF MOTHER (State or Country), Hampstead Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank J. Peterson

(Address) 7621 Greenmount

15-

Robert P. Harrison,

Filed ....., 191....

1921 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6/20 1921, to 6/21 1921, that I saw him alive on 6/20 1921, and that death occurred, on the date stated above, at 5.20 m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 16 yrs. / mos. / ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Kidney block (Duration) / yrs. / mos. 4 ds.

(Signed) Pressley S. Stanley Gosnell M. D.

6/21, 1921. (Address) 24 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Westminster DATE OF BURIAL, June 24 1921

UNDERTAKER Wm Cade & Son ADDRESS 502 E Baltimore

D 54786 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54786

CERTIFICATE OF DEATH.

169

1-PLACE OF DEATH South Plant, Baltimore Dry Docks REGISTERED NO. C

CITY OF BALTIMORE (No. and Ship Building Co. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Hofmann.

(Residence in Baltimore: No. 704 Cumberland St. 52 ------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, Do not know. (Month), 1 (Day), ... (Year)

7-AGE, 52 yrs. ---------- mos. ---------- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plant protector.
(b) General nature of industry, business, or establishment in which employed (or employer): Ship

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma V. Hofmann. (wife)

(Address) 704 Cumberland St.

15-

Filed ....., 191.... Robert F. Harrison, Registrar.

31921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 21st. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally drowned by falling from a tow line.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

June. 23 1921 (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lincoln Park Cem. DATE OF BURIAL, June 24 1921

20-UNDERTAKER William Cook ADDRESS 402 E. Pratt

D 54787 HEALTH DEPARTMENT—CITY OF BALTIMORE 184 D 54787

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 312 N Paca ST. 4 WARD) REGISTERED NO. C

2-FULL NAME Anna Ferritti

(Residence in Baltimore: No. 312 N Paca St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sngle

6-DATE OF BIRTH, Aug (Month) 6 (Day), 1920 (Year)

7-AGE, yrs. 10 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, John Ferritti

11-BIRTHPLACE OF FATHER (State or Country). Italy

12-MAIDEN NAME OF MOTHER Flora Lamorattina

13-BIRTHPLACE OF MOTHER (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Dimarco

(Address) 326 S Howard

15-

Filed....., 191.... Robert F. Harrison, Registrar.

Burial Permit Clerk.

JUN 23 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jun (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest, autopsy or inquiry.~~ thereon and from the evidence obtained by said ~~inquest, autopsy or inquiry.~~ Inq find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) None

(Duration) .....yrs. .....mos. .....ds.

(Signed) H. K. Gorsuch M. D. (Coroner.)

6-23, 1921. (Address) 111 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, 6/24/, 1921

20-UNDERTAKER, John J Fahey & Son — ADDRESS 1318 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

D 54788 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54788

CERTIFICATE OF DEATH. 184

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 312 N Paca, ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Flora Zerrith

(Residence in Baltimore: No. 312 N Paca, St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Mar'd

6-DATE OF BIRTH, ... Sept (Month) 8 (Day), 1903 (Year)

7-AGE, 18 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Vincent Lomonaco

11-BIRTHPLACE OF FATHER (State or Country) Italy

12-MAIDEN NAME OF MOTHER Flora Saccio

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lomonaco

(Address) 926 S Howard

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

JUN 23 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jun (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au~~ ..... find that said deceased came to her death ~~(opsy or~~ inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

(Duration) ..... yrs. a few hrs. ds.

CONTRIBUTORY (Secondary) probably Homocide

(Duration) ..... yrs. a few mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Jun 23 1921 (Address) 41 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, 6/24, 1921

20-UNDERTAKER, John F Fahey Sons — ADDRESS 1318 Light St.

Item of information should be carefully supplied. Failure properly classified. Examination of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54789

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54789

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 S Washington ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna M Walinski

(a) RESIDENCE NO. 508 S Washington ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) april 28 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or t... (State or country) Baltimore

PARENTS

10 NAME OF FATHER Andrew Walinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Johanna Walinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Andrew Walinski 508 S Washington

15 Filed Robert P. Harrison, Registrar

JUN 23 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1921, to June 22, 1921, that I last saw h[illegible] alive on June 22, 1921, and that death occurred, on the date stated above, at 1030 P m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis & pleu pneu

white

(duration) yrs. mon. 8 ds.

CONTRIBUTORY (Secondary) asthma & chronic bronchitis

(duration) yrs. mon. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & symptom

(Signed) [illegible] M. D.

, 19 (Address) 1623 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Rosary June 24 1921

20 UNDERTAKER — ADDRESS

John M Weber 1803 Bank

Information should be carefully supplied, so that it may be properly classified. Each question must be answered. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54790

CERTIFICATE OF DEATH.

138 D 54790

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 607 E. Fort Ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Horist

(a) RESIDENCE NO. 609 E. Fort Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ambrose Horist

6 DATE OF BIRTH (month, day, and year) May 17. 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) B. C. Pumdel Co Md

PARENTS

10 NAME OF FATHER Levi Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co Md

12 MAIDEN NAME OF MOTHER Alice V. Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md

14 Informant Ambrose Horist

(Address) 609 E. Fort Ave

15 JUN 24 1921 (Address) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20. 1921, to June 23. 1921.

that I last saw h-- alive on June 23 1921

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH was as follows:

~~Pulmonary~~ ~~T. Bomb~~

Acute Endocarditis 20m

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bilmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Levi V. Kennedy M. D.

, 19 (Address) 800 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemtery — DATE OF BURIAL: June 24th 1921

20 UNDERTAKER: Mrs John M. Deufel — ADDRESS: 801 Baltimore

information should be carefully supplied. Exact statements of fact may be properly classified. Exact statements of fact may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Seven months pregnant
+ Had Albuminuria.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Campfield.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54791

CERTIFICATE OF DEATH.

64 D 54791

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 N. Dunham ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Campfield

(a) RESIDENCE. NO. 104 N. Dunham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unmarried

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work

(b) General nature of industry, business, or establishment in which employed (or employer) house work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ezra Howard Campfield

(Address) 408 n Bond st

15 Filed JUN 24 1921 19 ROBERT I. KRAUSE Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22-1921

17 I HEREBY CERTIFY, That I attended deceased from 6-8-1921, to 6-22-1921.

That I last saw h[illegible] alive on 6-21-1921,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) — yrs. — mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. H. Campbell, M. D.

6-23-1921 (Address) 611 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodberry cemetery	June 24 1921
20 UNDERTAKER	ADDRESS
Edward Bryan	403 n Bond

mation should be carefully supplied. Exact statement of facts CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54792

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2520 Brookfield Ave ST.; 13 WARD)

2-FULL NAME Harry Sonnschill

(a) RESIDENCE. NO. 2520 Brookfield Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/0 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 30 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk Clothing

(b) General nature of industry, business, or establishment in which employed (or employer) L Greif & Bro

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lewis Sonnschill

11 BIRTHPLACE OF FATHER (city or town) Bavaria (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Pragl

13 BIRTHPLACE OF MOTHER (city or town) Bavaria (State or country) Germany

14 Informant (Address) Lewis Sonnschill 2520 Brookfield Ave

15 Filed JUN 24 1921 ROBERT A. BRAUNE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 22 1921, that I last saw him alive on June 22 1921, and that death occurred, on the date stated above, at 5:45A m.

The CAUSE OF DEATH* was as follows:

Enlarged prostate - Cystitis

Uric psychosis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Terminal pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jno A Schreter, M. D.

, 19 (Address) 1025 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL June 24 1921

20 UNDERTAKER J Ahrens & Co

ADDRESS 1611 Madison Ave

CAUSE OF DEATH should be carefully supplied. Exact statement of occupation should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. See instructions on back of certificates. TION is very important.

D 54793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 4 156

D 54793

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 312 N. Paca st. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John. Fritte

(Residence in Baltimore: No. 312 N Paca. St.; yrs., mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct (Month) 13 (Day), 1885 (Year)

7-AGE, 35 yrs. 8 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... 009

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Tonie Fritte

11-BIRTHPLACE OF FATHER (State or Country). Italy

12-MAIDEN NAME OF MOTHER Mt Known

13-BIRTHPLACE OF MOTHER (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Western Pdin State

(Address) Rm 22

15- JUN 24 1921 ROBERT B KRAUTER Registrar. Filed ....., 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jun (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (~~Inquest, autopsy or inquiry.~~)

thereon and from the evidence obtained by said..... (~~Inquest, or autopsy or~~ inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating gas

(Duration) ..., yrs. ..... mos. a few hrs

CONTRIBUTORY (Secondary) Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Gorsuch M. D. (Coroner)

6/23, 1921. (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence California

19-PLACE OF BURIAL OR REMOVAL, Bethesda Cemetery

DATE OF BURIAL, June 24 1921

20-UNDERTAKER W. M. Routson

ADDRESS 230 N Gilmor

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 54794

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54794

151

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 McCulloh ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Ames

(Residence in Baltimore: No. 1920 McCulloh St.; ..... yrs., 4 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male colored

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. June 23, 1921 (Month) (Day) (Year)

7-AGE. ..... yrs. 5 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Not any

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Harry J Ames

11-BIRTHPLACE OF FATHER (State or Country) Camden N.J.

12-MAIDEN NAME OF MOTHER Annie L Garrett

13-BIRTHPLACE OF MOTHER (State or Country) A.A. Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) 1320 McCulloh St

(Address) Harry J Ames

15- ROBERT E KRAUTER

Filed JUN 24 1921 191.... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 23, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1921, to June 23 1921, that I saw h[illegible] alive on June 23 1921, and that death occurred, on the date stated above, at 12 5/6 m.

The CAUSE OF DEATH* was as follows:

Stillborn

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas L Stewart M. D.

June 23, 1921 (Address) 704 W Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn

DATE OF BURIAL. June 24 1921.

20-UNDERTAKER Fidelity Co Dept

ADDRESS 622 Mulberry St

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

6607

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54795

CERTIFICATE OF DEATH.

424 54795

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ~~St.~~ 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Lamb

(a) RESIDENCE. No. 1001 E. Eager St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John Cliff

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Annie Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JUN 24 1921 19 ROBERT J. BRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1921

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1921, to June 22, 1921, that I last saw her alive on June 22, 1921, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Vestibule surrounding Urethral orifice ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 13/1921

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) F. A. Holden, M. D.

6/22/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 24 1921
20 UNDERTAKER	ADDRESS
Henry Hosch Son	1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54796

CERTIFICATE OF DEATH.

159 D 54796

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Colgate Creek, ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Orbin G. Lewis

(Residence in Baltimore: No. 1803 Guilford Ave. St. 7yrs mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Jan. ....., 1883
(Month) (Day) (Year)

7-AGE, 38 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Instructor
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Mechanic Arts

9-BIRTHPLACE, (State or Country), Ind.

PARENTS.

10-NAME OF FATHER, John W. Lewis

11-BIRTHPLACE OF FATHER (State or Country) Ind

12-MAIDEN NAME OF MOTHER, Savania Lewis

13-BIRTHPLACE OF MOTHER (State or Country), Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. G. Moran

(Address) 300 E Baltimore

15- Filed JUN 24 1921 191.....

[illegible] Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June ..... 22, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound.
Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. Clinton Black M. D.
(Coroner.)

6/22/1921 (Address) 1436 Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lindon Park Cem.

DATE OF BURIAL, June 24 1921

20-UNDERTAKER J. G. Moran

ADDRESS 300 E Baltimore

N. B.—Every item of information above must be carefully classified. Exact statement of OCCUPATION is important. In the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 54797

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2741 Belair Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Sommer

(a) RESIDENCE. NO. 2741 Belair Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Sommer

6 DATE OF BIRTH (month, day, and year) Jan 13-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brewer. 043

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Sommer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna Sommer
(Address) 2741 Belair Ave

15 Filed JUN 24 1921
BOBERT J. KRAUSER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1915, to June 22, 1921, that I last saw h.. alive on June 21, 1921, and that death occurred, on the date stated above, at 5.25 P. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis.
Chronic Nephritis.
Hypertrophy & Dilatation of Heart.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis 2 days.
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Curtis Lenneth, M. D.

, 19 (Address) 928 Holmead Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 24 1921
20 UNDERTAKER	ADDRESS
J Kenig & Co	2008 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54798 | 164 | D 54798

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. (Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Connelly

(a) RESIDENCE. No. 6522 Fait Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Estrude Connelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address) J H H

15 Filed JUN 24 1921 Registered LOVER'S [illegible] Burial permit 07858

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 22 —, 1921, to June 22 —, 1921, that I last saw h[illegible] alive on June 22 —, 1921, and that death occurred, on the date stated above, at 5 50 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) Wilbur Cornell, M. D.

19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: June 26 1921

20 UNDERTAKER: J Kerwig & Co — ADDRESS: 2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be readily understood. Abbreviations should not be used. Any physician who refuses or neglects to fill out and sign this certificate, or who certifies falsely, is liable to a penalty of $100 for each offense. See Section 125 of Ordinance No. 1 of 1915. Read carefully the instructions on back of certificates. TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105 ✓ D 54799

D 54799
1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No 1350 Towson St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Raymond Jackson

(a) RESIDENCE. NO. 1350 Towson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Curtis D. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Gillian M. Boid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Newport R.I.

14 Informant Curtis Jackson
(Address) 1350 Towson St.

15 FILED JUN 24 1921 ROBERT E. LEE TUTEN Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 22, 1921, that I last saw him alive on June 21, 1921, and that death occurred, on the date stated above, at 2.45 A. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis (duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs.

(Signed) Sidney H. Street, M. D.

1924 (Address) 408 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	June 1921
20 UNDERTAKER	ADDRESS
Margaret S. Flynn	1422 Eighty St.

MATION should be written in ink and in CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54800

CERTIFICATE OF DEATH.

92 D 54800

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Weine

(a) RESIDENCE. NO. 2019 St. Paul ST. over WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 8-9-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate. C.86

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Argentina.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Church Home Records (Address)

15 Filed JUN 24 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to June 23, 1921, that I last saw h[illegible] alive on June 22, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Purulent Meningitis
Pneumonia. Lobar R+L
21.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Ether Suppressed in Mastoiditis

(duration) yrs. 2 mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 31, 1921

Was there an autopsy?

What test confirmed diagnosis? Lumbar Puncture.

(Signed) W. D. Noble, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 6/24 1921

20 UNDERTAKER H. E. Hughes 1st & Broadway — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Failure to properly fill out certificates. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Residence at 2019
St Paul St
3 yrs

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54801

D 54801

CERTIFICATE OF DEATH.

REGISTERED NO. C 42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 N Monroe ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Hyde

(Residence in Baltimore: No. 26 N. Monroe St abt St.: 30 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) Sept 22 (Day) 1867 (Year)

7-AGE, 53 yrs. 9 mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Nurse (b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Georgia

PARENTS.

10-NAME OF FATHER. David Malone

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Dent Hood

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C M Abbott

(Address) 26 N Monroe st

15- JUN 24 1921 BURIAL PERMIT Registrar.

CAUSE OF DEATH in plain terms. So that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 23, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 — 1921, to June 24 — 1921, that I saw her alive on June 22 — 1921, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Malignant Uterine Cyst

Prob'ly 10 or 12 years

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Toxaemia 4 or 5 days

(Duration) yrs. mos. da.

(Signed) Clara M Cobb M. D.

June 23, 1921. (Address) 107 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral

DATE OF BURIAL. June 24, 1921

20-UNDERTAKER Johnston's

ADDRESS 111 N Fremont

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54802

REGISTERED NO. 794 54802

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Joseph Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred G. Rudolph

(a) RESIDENCE. NO. 1730 N. Port St ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs 3 mos 27 ds. How long in U. S., if of foreign birth? 37 yrs 3 mos 27 ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 25 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	3	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Woodworker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Geo. Rudolph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Annie Budde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Herman Rudolph
(Address) 1230 N. Port St

15 FUNERAL DIRECTOR'S ADDRESS

JUN 24 1921

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1921, to June 22, 1921, that I last saw h[illegible] alive on June 22, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema over 4 hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia due to Cerebral Hem (duration) yrs. mos 8 hrs. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. C. Grant, M. D.

June 22, 1921 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	June 25 1921

20 UNDERTAKER Philip Herrig ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations may be used. Read carefully the instructions on back of certificates. TION is very important. See instructions on back of

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.) "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Valvular Disease of the Heart

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54803

CERTIFICATE OF DEATH.

X 28 D 54803

1-PLACE OF DEATH US. Public Health Hosp. #56

REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hawkins

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., 39 WARD Fort McHenry Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
24 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar
(Address) US. PHS Hosp. #56 Ft McHenry Md.

15 Filed JUN 24 1921 19 ACCEPTED FOR FILING Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11 1921, 19 ..., to June 22 1921, 19 ..., that I last saw him alive on June 22 1921. 19 ..., and that death occurred, on the date stated above, at 11'45A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic far adv. active.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) ----- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Exam Lab. report

(Signed) Thomas R. Rayner, M. D.
Senior Surgeon (R)

, 19 (Address) US. PHS Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL June 24 1921

20 UNDERTAKER A. Lindower — ADDRESS 120 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Explain abbreviations on back of certificates. MEDICAL ATTENDANCE AS TO CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54804

CERTIFICATE OF DEATH.

D 54804

1-PLACE OF DEATH US Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST., 34 WARD)

REGISTERED NO. 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willaim Page.

(a) RESIDENCE NO. US. Public Health Hosp. #56 Fort McHenry Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
39 yrs.	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ---

(c) Name of employer: ---

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Edgar T Rosenbrock Registrar

(Address) US. PHS Hosp. #56 Ft McHenry Md.

15 FILED JUN 24 1921 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10 1921, to June 23 1921, that I last saw him alive on June 23 1921, and that death occurred, on the date stated above, at 9'30 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis general

Nephritis Interstitial. yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of -0-

Was there an autopsy? Yes.

What test confirmed diagnosis? Exam Lab report

(Signed) Thomas B Page M.D. Senior Surgeon

, 19 (Address) USPHS Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: June 24 1921

20 UNDERTAKER: J. C. Kleinert

ADDRESS 1127 E Baltimore St

IMPORTANT—Write plainly with ink. Do not use lead pencil. Be sure that it may be properly classified. Each question must be answered. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 54805

HEALTH DEPARTMENT—CITY OF BALTIMORE

A 28 D 54805

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Curtis Sydenstricker

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., 40 WARD Ft McHenry Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27 yrs.	- ---	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 032

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar
(Address) US. PHS Hosp. #56 Fort McHenry

15 Filed JUN 24 1921 BOREE [illegible]
Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from May 16 1921, to June 22 1921. 19 ....,
that I last saw h. im alive on June 22 1921, 19 ....,
and that death occurred, on the date stated above, at 12°20 A.M.
The CAUSE OF DEATH* was as follows:

Tuberculosis chronic far adv active.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) ---- (duration) ....yrs. mos. ds.

18 Where was disease contracted if not at place of death? US. Army

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Exam Lab. report

(Signed) Thomas B. Taylor M. D.

. 19 (Address) Senior Surgeon (R) US. PHS Hosp. #56

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Huntington W. Va

DATE OF BURIAL June 24 1921

20 UNDERTAKER E. Simmons

ADDRESS 1127 E Balto St

mation should be entered. EXACT statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

14 72406 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54806

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Bolles

(a) RESIDENCE. No. 6 Berkley St. Cambridge St. Mass Ward. Cambridge Mass.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Miss Elinor G. Bolles (Daughter) 6 Thompson St Annapolis Md

6 DATE OF BIRTH (month, day, and year) Sept 27, 1853

7 AGE: 67 Years; 8 Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H W. 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maine

PARENTS

10 NAME OF FATHER: Joshua A. Swarith.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass.

12 MAIDEN NAME OF MOTHER: Sarah Hodges.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed JUN 24 1921 ROBERT J. KRAUTH Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1921, to June 24, 1921, that I last saw h.e.r alive on June 24, 1921, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia.

(duration) 3 yrs. 3 mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hypertension, Myocardial Dis. (duration) 5 yrs. 10 mos. 6 ds.

18 Where was disease contracted if not at place of death? Cambridge, Mass.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood Examinations

(Signed) J R Mason, M. D.

(Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Boston Mass. DATE OF BURIAL: June 24 1921

20 UNDERTAKER: Henry W Jenkins & Son 60 ADDRESS: Orchard & McCollough

CAUSE OF DEATH in plain terms, so that it may be properly classified. Indefinite statements such as "Heart Failure" or "Old Age" are not sufficient. Abbreviations should not be used. Name of disease causing death, or in deaths from violence, the nature of injury, must be stated in every case. Omission of any item of information required by this certificate may be cause for withholding burial permit. See back of certificates. CAUSE OF DEATH must be signed by physician. Name of attending physician must be given. Certificate of death must be filed with Registrar of Vital Statistics before burial. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54807

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 Pinsbury ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Brunnett.

(a) RESIDENCE. NO. 2212 Pinsbury ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced (or) WIFE of Christian Brunnett

6 DATE OF BIRTH (month, day, and year) Feb. 17th 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Blin Rykhorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Grmany

12 MAIDEN NAME OF MOTHER Elmeline Krumpk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Grmany

14 Informant Dora Hoffman
(Address) 2212 Pinsbury St

15 Filed JUN 24 1921 19 ROBERT J. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5, 1919, to June 23, 1921, that I last saw her alive on June 22, 1921, and that death occurred, on the date stated above, at 5:50 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) chronic nephritis

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hypertrophy + bronchial adhes

(Signed) Maurice E. Shamer, M. D.

6/23, 1924 (Address) 3300 N. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	25 June 1921
20 UNDERTAKER	ADDRESS
Wilbur W. Shriver	1018 Edmonds

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. This certificate should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54808

D 54808

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Home for Aged of the H. Eden. St.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Derr.

(a) RESIDENCE. NO. S.E. Cor. Franklin and Fulton St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29-1836.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Derr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Vashti Sank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant James M. Derr
(Address) 208 N Hilton St.

15 Filed JUN 24 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17

I HEREBY CERTIFY, That I attended deceased from Jany 1, 1921, to June 23, 1921.

that I last saw h. in alive on June 22, 1921.

and that death occurred, on the date stated above, at 10.25A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of None

Was there an autopsy? No.

What test confirmed diagnosis? No

(Signed) George C. Shannon M. D.

6/24 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Eastern Cemetery	June 25 1921

20 UNDERTAKER George J. Smith ADDRESS 1000 E Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54809

CERTIFICATE OF DEATH.

50 D 54809

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2227 Homewood Avenue ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of st eet and number.)

2-FULL NAME Matilda J. Adams

(a) RESIDENCE. NO. 2227 Homewood Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Adams

6 DATE OF BIRTH (month, day, and year): Feb. 25, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 007

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Orange, New Jersey

PARENTS

10 NAME OF FATHER: Frederick Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Kerber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mr. John Adams, 2227 Homewood Avenue

15 Filed JUN 24 1921 ROBERT J. [illegible] Registrar
Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. PARTICULAR ATTENTION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/22 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2 1926 to June 22 1921 that I last saw h[illegible] alive on June 22 1921 and that death occurred, on the date stated above, at 10 Pm.

The CAUSE OF DEATH* was as follows:

Diabetis mellitus

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) coma

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1919

Was there an autopsy? yes

What test confirmed diagnosis? Sugar Tolerance

(Signed) W. R. Kelly M. D.

6/24 1921 (Address) 6 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	6/25 21
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54810

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54810

CERTIFICATE OF DEATH.

1201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 W. Mulberry St. ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Sullivan Sr.

(a) RESIDENCE. NO. 1009 W. Mulberry St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Sullivan

6 DATE OF BIRTH (month, day, and year) Jan. 4th 1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseshoer (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 036

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Daniel Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Johanna Griffen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Johanna Sullivan (Address) 1009 W. Mulberry St.

15 Filed JUN 24 1921 ROBERT J. REUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 1 1920 to June 22 1921 that I last saw him alive on June 22 1921 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

Senile Arteriosclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Dietz M. D.

(Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 25 19 21
20 UNDERTAKER Joseph L. Cook	ADDRESS 1003 W Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

D 54811

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 54811

Registered No. C 1074

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2412 Fleet St. St.: 1 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louis a Piechocki

(Residence in Baltimore: No. 2412 Fleet St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
male	white	Single

6 DATE OF BIRTH aug (Month) 31 (Day) 1920 (Year)

7 AGE yrs. 9 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) — 000

9 BIRTHPLACE (State or country) Baltimore

PARENTS

10 NAME OF FATHER albert Piechocki

11 BIRTHPLACE OF FATHER (State or country) Poland

12 MAIDEN NAME OF MOTHER agnes Kwasnik

13 BIRTHPLACE OF MOTHER (State or country) Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) albert Piechocki

(Address) 2412 Fleet St

15 Filed JUN 24 1921, 191 ROBERT J. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 24 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1921, to June 24 1921, that I saw him alive on June 24 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Allen C. Beecham M. D.

June 25, 1921 (Address) 3134 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Stanislaus | DATE OF BURIAL June 25, 1921

20 UNDERTAKER John M Weber | ADDRESS 1803 Bank St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Riebsam

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54812 104 D 54812

D 54812

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Masonville St.: 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Riebsam

(Residence in Baltimore: No. Masonville St.: ....yrs., 5 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dec. (Month) 28 (Day), 1920 (Year)

7-AGE, ...yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE. (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Riebsam

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Helen Baily

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Helen Riebsam

(Address) Brooklyn Md

15- Filed JUN 24 1921, 191.... Registrar. [illegible]

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 24 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1921, to June 24 1921, that I saw h[illegible] alive on June 21 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. F. Brooks M. D.

June 24, 1921. (Address) Brooklyn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, June 27 1921

20-UNDERTAKER Geo. H. Schwab — ADDRESS 2101 Eutaw Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

17563 D. 54813

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

74 D. 54813

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustave Lutkin.

(a) RESIDENCE. NO. Germantown Md. ST., WARD. Germantown Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20. 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Scott L. Dickerson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gunnison Bolander

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Johns Hopkins Hosp records
(Address)

15 JUN 24 1921 [redacted] Registrar

Burial Form 1 Ulor

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 - 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 4, 19 21, to June 24, 19 21, that I last saw h[er] alive on June 24, 19 21, and that death occurred, on the date stated above, at 7:45 a. m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 1 yrs. mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? Yes Date of 6/15/21

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation & autopsy

(Signed) H. H. Young, M. D.

6-24-21 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clappers, Md.	June 19 21
20 UNDERTAKER	ADDRESS
H. E. Wyckoff & Son	1724 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or initials. Any cause which may be peculiar to females should be so stated. Consult list on back of certificates. TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54814

D 54814

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edmondson Ave & North Bend Lane ST. 178 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ray Ridgely

(a) RESIDENCE. No. Edmondson Ave & North Bend Lane ST., WARD.
(Usual place of abode) 2d house East of City Line (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mayone J. Ridgely

6 DATE OF BIRTH (month, day, and year) Sep 17 - 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Dr James T Ridgely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co.

12 MAIDEN NAME OF MOTHER Ridgway Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Dr James T Ridgely (Address) 4608 Maryland Ave

15 JUN 24 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to June 20, 1921,

that I last saw h[illegible] alive on June 20, 1921,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

½ hr

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis ?

(duration) 0 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk

Did an operation precede death? No data of

Was there an autopsy? No

What test confirmed diagnosis? Hemorrhage.

(Signed) Marshall B Hurst, M. D.

, 19 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery Co.	June 22, 1921
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Kazmierski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54815

D 54815

CERTIFICATE OF DEATH.

53

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 S. Durham ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryanna Kazmierski

(a) RESIDENCE. NO. 605 S. Durham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (a) HUSBAND of (a) WIFE of: Mikolaj Kazmierski

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home.

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Antoni Bukowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Rolkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Boleslaw Kazmierski 605 S Durham

15 Filed , 19 Registrar

JUN 24 1921 Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from May, 19 21, to Oct., 19 20, that I last saw h[illegible] r alive on Oct., 19 20, and that death occurred, on the date stated above, at 11 [illegible] m.

The CAUSE OF DEATH* was as follows:

Lymphatic Sarcoma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood, Examination

(Signed) [illegible], M. D.

, 19 21 (Address) 2[illegible]0 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary DATE OF BURIAL: June 25 1921

20 UNDERTAKER: William Falkowski & Co ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates.
TION is very important.

Spec.--6-9-19--H. P. Co.--1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54816

CERTIFICATE OF DEATH.

D 54816

REGISTERED NO. 1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Wright

(a) RESIDENCE. NO. 731 Grindall Court STREET. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5 - 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary garrison 6/24/21

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) James Wright 731 Grindall Ct

15 Filed JUN 24 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to June 23, 1921, that I last saw him alive on June 23, 1921, and that death occurred, on the date stated above, at 10:45a m.

The CAUSE OF DEATH was as follows:

Diphtheria — nasal, tonsillar, pharyngeal & laryngeal

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture positive

(Signed) [illegible] M. D.

(Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 24 1921

20 UNDERTAKER John H. Toadvine ADDRESS 1423 Hillsdale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54817

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54817

CERTIFICATE OF DEATH.

182 ✓

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Joseph Hospital St.; 7 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward O. Larson.

(Residence in Baltimore: No. 1710 Thames. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) unknown

6-DATE OF BIRTH, unknown (Month) ....., 1 (Day) ..... (Year)

7-ACE, about 73 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), unknown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. H. C. Blades

(Address) 143 N. Broadway

15-

Filed JUN 24 1921, 191...

Robert F. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wounds 1/2 hr

(Duration) ..... yrs. ..... mos. 1/2 hr

CONTRIBUTORY (Secondary) Internal Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. C. Blades M. D.
(Coroner.)

191... (Address) 1436 Gray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

18-PLACE OF BURIAL OR REMOVAL, St. Patrick Cem

DATE OF BURIAL, June 24, 1921

20-UNDERTAKER Chas. F. Evans & Son

ADDRESS 118 S. Mt. Royal Ave

Exact statement of OCCUPATION necessary to be properly classified. Write CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54818 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54818

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Swift

(a) RESIDENCE. No. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) January 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Co —

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sister Florence, (Address) Preston & Veley Sts.

15 Filed JUN 24 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from ... 19 ... to ... 19 ...

that I last saw her alive on June 19 1921

and that death occurred, on the date stated above, at 10.30 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

6 weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bed sores

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Warner, M. D.

June 24. 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	June 25 1921

20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmt Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

D 54819

D 54819

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 117 Montebello Terrace ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel V. Aler

(a) RESIDENCE. NO. 117 Montebello Terrace ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth Aler

6 DATE OF BIRTH (month, day, and year) Feby 2nd 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

PARENTS

10 NAME OF FATHER Jeremiah Aler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Deborah Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

11 Informant Elizabeth Aler (Address) 117 Montebello Terrace

15 Filed JN 24 1921 Robert P. Harrison, Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to May 20, 1921, that I last saw h[illegible] alive on June 21, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Compound fracture

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis

Myocarditis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Chas Simons, M. D.

June 23, 1921 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 27th 1921
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54820

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54820

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 122 Cypress ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H McFarland

(a) RESIDENCE. No. 122 Cypress ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yr. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kara McFarland

6 DATE OF BIRTH (month, day, and year) Dec 29 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John McFarland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Anthony

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary McFarland (Address) 122 Cypress St

15 JUN 24 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1921, to June 23, 1921, that I last saw him alive on June 23, 1921, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Heat prostration

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Old age,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm F. Morgan, M. D.

, 19 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvert	June 25 21
20 UNDERTAKER	ADDRESS
W. J. Tuckwood Sons	Bath

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54821

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54821

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hosp. ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary D. Jones.

(a) RESIDENCE. No. 151 St. Charles Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer Jones

6 DATE OF BIRTH (month, day, and year) July 1 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER J. M. T. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Melton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elmer Jones

(Address) 321 E. 14th St.

15 Filed JUN 24 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15 1921, to June 23 1921,

that I last saw h alive on June 23 1921

and that death occurred, on the date stated above, at 10.40 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis:

Mitral Stenosis:

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation: (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Fred J. Boerstler M. D.

6/23 1921 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: Woodlawn Cem June 27 21

20 UNDERTAKER — ADDRESS: Wm J Tickner & Sons North Ave

mation should be carefully supplied. Exact statement of facts may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54822

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54822

CERTIFICATE OF DEATH

REGISTERED NO. 14 X 53

1-PLACE OF DEATH Howard A Kelly Hospital

CITY OF BALTIMORE: (NO. 1418 Eutaw Place ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Marg Annie Pierson

(a) RESIDENCE. NO. Madison, N C ST., WARD. Madison N C

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan 1818

7 AGE: 23 (Years / Months / Days) — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 800

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Walnut Cove Stokes Co N C

PARENTS

10 NAME OF FATHER: Mr Grant Pierson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Walnut Cove Stokes Co. N C.

12 MAIDEN NAME OF MOTHER: Elden Tuttle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Walnut Cove Stokes Co. N C.

14 Informant (Address): Mr. J. C. Pierson [illegible] Madison N C

15 Filed JUN 24 1921 19 — Robert P. Harrison, Registrar — Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 20, 19 21, to June 24, 19 21, that I last saw her alive on June 24, 19 21, and that death occurred, on the date stated above, at 2.55 p.m.

The CAUSE OF DEATH* was as follows: Acute myeloid Leukaemia

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 6, 1921

Was there an autopsy? No

What test confirmed diagnosis? Blood examination.

(Signed) Robert E. Fricke, M. D.

19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Walnut Cove. Cleaspring N.C.

DATE OF BURIAL: June 24, 21

20 UNDERTAKER: Chas. S. Black

ADDRESS: 742 W. North Ave

mation should be carefully supplied. Exact statement may be properly classified. Exact statement CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 54823 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54823

CERTIFICATE OF DEATH. 91-079

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1456 Riverside ST. 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Ellen Bergan.

(a) RESIDENCE. No. 1456 Riverside ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U.S.

PARENTS

10 NAME OF FATHER John F. Bergen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Boyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince Edward.

14 Informant (Address) John F. Bergan Jr 1318 Light St.

15 Filed JUN 21 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/23 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/10, 1921, to 6/23, 1921, that I last saw her alive on 6/22, 1921, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis
myocarditis

(duration) dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) J. Edward Norris M. D.

6/23. 1921 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Cathedral.	6/25 1921
20 UNDERTAKER	ADDRESS
John F. Bergan Son	1318 Light St

mation should be carefully supplied. Age should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54824 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54824

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 N Hamilton Ave ST.: 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Rudolph Rouse

(a) RESIDENCE. No. 501 N. Hamilton Ave ST., 77 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 9 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At school 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick A Rouse

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Marie W. Müller

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Frederick A Rouse (Address) 501 N Hamilton ave

15 Filed JUN 21 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 8 1920 to June 23 1921 that I last saw him alive on June 23 1921 and that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geary A. Long M. D.

, 19 (Address) 27 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ned Cath. Cem.	6/27/21
20 UNDERTAKER	ADDRESS
Geo J Rutt	1735 Hartford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54825

CERTIFICATE OF DEATH.

50

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 141 E Randall ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth A Baker

(a) RESIDENCE. No. 141 E Randall ST.: 24 WARD. Mt. Airy Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles V. Baker

6 DATE OF BIRTH (month, day, and year) Sept 12 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

PARENTS

10 NAME OF FATHER Henry Norwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Cylvester Baker (Address) 5918 York Road

15 Filed JUN 25 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1921, to June 24, 1921, that I last saw h[illegible] alive on June 24, 1921, and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) A. R. Campbell M. D.

June 25, 1921 (Address) 44 Hancock St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Airy Md	6-25 1921
20 UNDERTAKER Edward B Hale	ADDRESS 115 E Preston

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

D 54826 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54826

CERTIFICATE OF DEATH.

REGISTERED NO. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 Morris ST.) 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Davis

(Residence in Baltimore: No. 903 Morris St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	

6-DATE OF BIRTH, June (Month) 23 (Day), 1921 (Year)

7-AGE, ...yrs....mos....da. If LESS than 1 day, 12 hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) 800

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Aaron Davis

11-BIRTHPLACE OF FATHER (State or Country) Pa

12-MAIDEN NAME OF MOTHER Hattie Buckler

13-BIRTHPLACE OF MOTHER (State or Country). Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Davis

(Address) 903 Morris St

15- Filed JUN 25 1921, 191.... Registrar.

Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 24 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from June 23 1921, to June 24th 1921, that I saw h— alive on June 24th 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows: Pneumonia Contributory

8 Months (Duration) yrs. mos. da.

Probably Lues CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) A. Fue Ellis, M. D.

6-24-, 1921. (Address) 924 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Johns Hopkins Med. School

DATE OF BURIAL, June 24, 1921

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54827

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 54827

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 h Durham St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Schackert

(Residence in Baltimore: No. 1810 h Durham St St. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) M

6-DATE OF BIRTH. December 30 (Month), 1873 (Day) (Year)

7-AGE. 48 yrs. 6 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Watchman
(b) General nature of Industry, business, or establishment in which employed (or employer). 062

9-BIRTHPLACE. (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. Michael Schackert

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Schackert

(Address) 1810 n. Durham st.

15-

Filed JUN 25 1921, 191

Robert P. Harrison, Registrar.

Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 24 1921, to June 23 1921, that I saw h[im] alive on June 22 1921, and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 5 mos. 24 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Albert Osswald M. D.

June 24 1921. (Address) 822 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mount Carmel Cemetery

DATE OF BURIAL. June 25, 1921

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Hereford ave

D 54828 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54828

CERTIFICATE OF DEATH. 1A 186

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. F. Robinson

(Residence in Baltimore: No. Robinson Md. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April (Month) 15 (Day), 1861 (Year)

7-AGE, 60 yrs. 2 mos. 9 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Saw mill operator
(b) General nature of industry, business, or establishment in which employed (or employer)..... 946

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm F Robinson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Armwell J Ripley

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth L Robinson

(Address) Robinson A.A.Co Md

15- Robert P. Harrison, 191.....

Registrar.

JUN 25 1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 24 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or inquiry.~~

thereon and from the evidence obtained by said ~~Inquest, au~~

~~topsy or inquiry.~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull - Chest crushed

(Duration) yrs. a few hours mos. ds.

CONTRIBUTORY (Secondary) struck by piece of board

(Duration) yrs. mos. ds.

(Signed) W K Fowler M. D.

(Coroner.)

6-25, 1924 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Robinson Md.

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, June 27, 1924

20-UNDERTAKER John F Denny

ADDRESS 715 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54829

D 54829

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 W. Woodland Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren Lee Lewis

(a) RESIDENCE. No. 2 W. Woodland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joanna I Lewis

6 DATE OF BIRTH (month, day, and year) Oct 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-Keeper

(b) General nature of Industry, business, or establishment in which employed (or employer) 008

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Reedville Va

PARENTS

10 NAME OF FATHER Dorsey E Lewis

11 BIRTHPLACE OF FATHER (city or town) Reedville (State or country) Va

12 MAIDEN NAME OF MOTHER Emma Haney

13 BIRTHPLACE OF MOTHER (city or town) Reedville Va (State or country)

14 Informant William R Lewis (Address) 2 W. Woodland Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

JUN 25 1921 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23d 1921

17

I HEREBY CERTIFY, That I attended deceased from May 21st, 1921, to June 23d, 1921, that I last saw him alive on June 22nd, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination & Sputum

(Signed) A. C. Bennett, M. D.

June 23d 1921 (Address) 4309 Roland Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK JUN 25 1921	19
20 UNDERTAKER JOHN F. DENNY	ADDRESS 716 LIGHT S

D 54830

D 54830

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1938 Ridgewood Ave. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Vincent McDermott

(a) RESIDENCE NO. 1938 Ridgewood Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 23 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	4	1	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Chas T. McDermott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Mabel Rediker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Chas T. McDermott (Address) 1938 Ridgewood Ave

15 Filed JUN 25 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 25th, 1921, to June 25th, 1921, that I last saw him alive on June 25th, 1921, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? His Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William J. Sullivan M. D.

6/26 1921 (Address) 17 E. Fulton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL June 25 1921

20 UNDERTAKER Thomas Fahey & Sons — ADDRESS 827 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54831

CERTIFICATE OF DEATH.

109

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE (No. Lombard & Green St. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond N. Fretwell.

(a) RESIDENCE. NO. 2413 E. Fayette St. ST.. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
m	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 29 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39.		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Jessie O. Fretwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.

12 MAIDEN NAME OF MOTHER Ida Shelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Jessie O. Fretwell (Address) 2413 E Fayette St

15 Filed ..... 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

N 25 1921

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17

I HEREBY CERTIFY, That I attended deceased from June 22 . 1921 . to June 23 . 1921 . that I last saw him alive on June 23 . 1921 . and that death occurred, on the date stated above, at 6.50 A m.

The CAUSE OF DEATH* was as follows:

Intest. Obstruction

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Jun 22-1924

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jno Hundley Jr M. D.

. 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	6/25 1921
20 UNDERTAKER J. A. Moran	ADDRESS 300 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54832 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54832

CERTIFICATE OF DEATH.

H 1

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 N Patterson Pl. ST.; ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Benjamin

(a) RESIDENCE. NO. 814 N Patterson Pl. ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Benjamin

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 097

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Wm Benjamin 814 N Patterson Pl.

15 Filed JUN 25 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-15 1921 to 6-23 1921, that I last saw her alive on 6-20 1921, and that death occurred, on the date stated above, at 11:00 m.

The CAUSE OF DEATH* was as follows: Carcinoma of Sigmoid Flexure (Contributory)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardio Fibrosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tenderness

(Signed) H. Burgess M. D.

6-24 1921 (Address) 800 N Patterson Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dale Cemetery. DATE OF BURIAL June 27 1921

20 UNDERTAKER Robt T Turner ADDRESS 1742 Pitcher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease may be insufficient. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54833 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54833

28 ✓

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2028 Hoffman ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude H. Steinman

(a) RESIDENCE. No. 2028 Hoffman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25-1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Binding 064

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Albright & Baltimore Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Frederick Steinman

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Reed

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mrs Ritz (Address) 1423 Jody St.

15 Filed JUN 25 1921 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to June 23, 1921, that I last saw h alive on ....., 19..... and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John T Avery, M. D.

19 (Address) 1603 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 27 1921
20 UNDERTAKER	ADDRESS
Mrs. Christian Miller	233 E Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.--6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54834

CERTIFICATE OF DEATH.

105 D 54834

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2 N. Fremont Ave. ST.: 18 WARD)

2-FULL NAME Charles E. Roath

(a) RESIDENCE. NO. 2 N. Fremont Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of :
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Worker 086

(b) General nature of industry, business, or establishment in which employed (or employer) Rosenfield Mfg. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James A. Roath

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Ellen T. O'Reill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Albert J. Roath
(Address) 19 W. Camden St.

15 Filed JUN 25 1921 19 Robert F. Carrigan Registrar

Burial Permit 61[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23" 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1921, to June 23, 1921.

That I last saw h[illegible] alive on June 23, 1921.

and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Mercer, M. D.

6-24 1921 (Address) 51 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 27 19
20 UNDERTAKER Joseph B Cook Co.	ADDRESS 1003 W Balto St.

CAUSE OF DEATH in plain terms, so that it may be understood by the public. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54835

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 54835

81

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Poole

(a) RESIDENCE. NO. 56 W. Biddle St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma A. Poole

6 DATE OF BIRTH (month, day, and year) Sept. 30th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (R.R.Man)

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) Manassas Co.
(State or country) Va.

PARENTS

10 NAME OF FATHER Mr. Poole

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Pauline Sibley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant (Address) Mrs. Julia Freund 56 W. Biddle St.

15 Filed JUN 25 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 14 1921, to June 22 1921, that I last saw h[illegible] alive on June 21 1921, and that death occurred, on the date stated above, at 8.35 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Collapse

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur W. Thompson M. D.

6/24 1921 (Address) 2806 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 25 1921
20 UNDERTAKER Joseph B. Cooley	ADDRESS 1003 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease alone is not sufficient. Deaths from violence must state the means of injury and whether accidental, suicidal or homicidal. Deaths from childbirth must state whether single or married. Deaths of infants must state whether legitimate or illegitimate. Deaths from contagious diseases must state the source of infection. Deaths from cancer must state the duration of the disease. Deaths from tuberculosis must state the organ affected. Deaths from fever must state the duration of the fever. Deaths from heart disease must state whether organic or functional. Deaths from paralysis must state whether hemorrhagic or embolic. Deaths from pneumonia must state whether lobar or bronchial. Deaths from kidney disease must state whether acute or chronic. Deaths from old age must state the principal diseases and contributory causes. Deaths from accident must state the nature of the accident. Deaths from operations must state the nature of the operation. Deaths from unknown causes must be reported to the Coroner. Deaths from natural causes must be certified to by a physician. Deaths from violence must be reported to the Coroner

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54836

D 51836

CERTIFICATE OF DEATH.

78

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 932 Dover ST.: 21 WARD)

2-FULL NAME Mary Brown

(a) RESIDENCE. NO. 737 Dover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Col	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo. W. Brown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) General House work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Horace Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hyman Brown (Address) 2-2 Otterbein

15 Filed Robert P. Harrison, Registrar

N25 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/23/1921

17 I HEREBY CERTIFY, That I attended deceased from 4/18/21, to 6/23/21, that I last saw her alive on 6/21/21, and that death occurred, on the date stated above, at 2:15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc

(duration) about 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Lew Engler M. D.

, 19 (Address) 908 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Auburn Cemetery	6/25 1921
20 UNDERTAKER	ADDRESS
Wm. Scott Hooper & Son	908 W. Conway St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or initials. Consult list of diseases on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54837 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54837

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital, Bay View St.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Herbig

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Herbig

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed JUN 25 1921, 19 Robert F. Hartman, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to June 24, 1921, that I last saw him alive on June 23, 1921, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall-bladder

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) Bloodgood, M. D.

6/24/1921 Address) New City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk	June 26 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 S Mont

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54838 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 54838

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospitals, Bay View ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Smith

(a) RESIDENCE. NO. Unknown ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred ~~unknown~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospitals.

15 Filed JUN 25 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1921, to June 23, 1921, that I last saw h.er alive on June 23, 1921, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) Roseman, M. D.

6/23/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lamal Cemetery

DATE OF BURIAL 6/27 1921

20 UNDERTAKER Felix B Page

ADDRESS 1122 mulberry st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Physicians are requested to fill in all items of certificates. TION is very important. See instructions on back of certificate.

54839 D 54839

HEALTH DEPARTMENT—CITY OF BALTIMORE

54839 D 54839

CERTIFICATE OF DEATH.

1561

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2712 N Gulford St. 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward F. Thompson

(Residence in Baltimore: No. 2712 N Gulford Ave St.; yrs. 6 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: May 24, 1855 (Month) (Day) (Year)

7-AGE: 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: General Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 1045

9-BIRTHPLACE, (State or Country): Irvington Va.

PARENTS.

10-NAME OF FATHER: Edwin Thompson

11-BIRTHPLACE OF FATHER (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Nel Kamm

13-BIRTHPLACE OF MOTHER (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. J. Warren.

(Address) 2712 Gulford Ave

15- Filed JUN 26 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia
Ill Gas. Suicide
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(Duration) yrs. mos. ds.

(Signed) F. C. Blades M. D.
(Coroner)

June 24 1921. (Address) 1431 E Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Irvington Va — DATE OF BURIAL, June 26 1921

20-UNDERTAKER E A Windfield — ADDRESS 501 E 22 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

148950 54840 54840

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 10-061 D 54840

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. Johns Hopkins Hospital. ST. 7 WARD)

2-FULL NAME William Simpson.

(a) RESIDENCE. No. Kensington, Md. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary & William Simpson (Parents)

6 DATE OF BIRTH (month, day, and year) Aug. 13, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 801

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Simpson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Rogers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital Record

15 Filed JUN 26 1921 ROBERT I. GRIFFITH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 18 1921 to June 24, 1921 that I last saw him alive on June 24, 1921 and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis (B. influenzae)

(duration) yrs. — mos. 2 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Lumbar puncture & cultures

(Signed) W Emerson, M. D.

, 19 (Address) A.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sandy Springs md

DATE OF BURIAL June 23 1921

20 UNDERTAKER Montgomery Co John H Tradewell

ADDRESS 142 Weskit St

CAUSE OF DEATH to be filled in plainly, preferably with ink. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 54841 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54841

CERTIFICATE OF DEATH. 40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 E Fayette ST. 5 WARD)

2-FULL NAME Rosa Caplan

(a) RESIDENCE. NO. 1008 E Fayette ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs — mos. — ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Caplan

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 57 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nane 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abba Zisping

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Minour

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: David Caplan (Address) 1008 E Fayette

15 Filed JUN 26 1921 ROBERT CRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1920, to June 24, 1921, that I last saw her alive on June 24, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wesley Mc M. D.

(Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Blair Rd. DATE OF BURIAL: June 26 1921

20 UNDERTAKER: Max Levinson ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. All certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54842 — 1365 — D 54842

CERTIFICATE OF DEATH.

1-PLACE OF DEATH President St

CITY OF BALTIMORE: (No. 413-415 W Fayette St.; 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lockland

(a) RESIDENCE. NO. 1324 N. Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morcellus Lockland.

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wife. 037
(b) General nature of industry, business, or establishment in which employed (or employer) House work
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Stephen Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Charlotte Towns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Morcellus Lockland.
(Address) 1321 N. Calhoun St.

15 Filed JUN 26 1921 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1921, to June 24, 1921, that I last saw h[illegible] alive on June 24, 1921, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Ante or Post Partum Hemorrhage
(duration) yrs. mos. 2 hs. ds.

CONTRIBUTORY (Secondary) Transverse Presentation & Spontaneous Delivery
(duration) yrs. mos. 8 hs. ds.

18 Where was disease contracted if not at place of death? 1321 N. Calhoun
Did an operation precede death? 4 hs. Date of Version to control Bleeding
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination

(Signed) William H. Wright, M. D.
June 24 1921 (Address) 1209 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 27 1921
20 UNDERTAKER Joseph A Farrell	ADDRESS 4319 Dunkirk Rd

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Bukie Sandler.

D 54843

HEALTH DEPARTMENT—CITY OF BALTIMORE

166

CERTIFICATE OF DEATH.

D 54843

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1809 E. Fairmount St. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME [redacted] Sandler

(Residence in Baltimore: No. 1809 E. Fairmount St.; yrs., mos. ds.)

28

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	M

6-DATE OF BIRTH, Unknown (Month) (Day), 1872 (Year)

7-AGE 49 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore St.

15-

Filed JUN 26 1921 ROBERT J. KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis, hemiplegia

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) J. K. Smiley M. D.
(Coroner)

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem.	June 27th, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E. Balt

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 54844

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

166

D 54844

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1809 E. Fairmount St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Baron

(Residence in Baltimore: No. 1809 Fairmount Ave St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	M

6-DATE OF BIRTH, unknown (Month) ....., 1899 (Day) (Year)

7-AGE, 22 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0.37

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Meyer Sundber

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Beckie

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balto St

15-

Filed JUN 26 1921 191..... ROBERT J KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Jan. (Month) 24 (Day), 191.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia by Burning

Building (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Kelly Finley M. D. (Coroner)

....., 191... (Address) 4 Law

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mosher Circle	6/28/21

20-UNDERTAKER	ADDRESS
Joe K Lewis	1411 Eastern

N. B.—Every item of information should be carefully considered, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54845

CERTIFICATE OF DEATH.

166 D 54845

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1809 E Fairmount ave ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sara Sandler

(Residence in Baltimore: No. 1809 E Fairmount ave Left St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) S

6-DATE OF BIRTH, Unknown (Month) (Day), 1907 (Year)

7-AGE, 12 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Meyer Sandler

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Beckie —

13-BIRTHPLACE OF MOTHER (State or Country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S Lewis

(Address) 1411 E Balto St

15- ROBERT J KRAUTER

Filed JUN 26 1921 191... Burial Permit Given Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Conflagration Burning

Smothering (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. ds.

(Signed) Abram Jaslow (Coroner) M. D.

, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Northern Circle | DATE OF BURIAL, Jan 26 1921

20-UNDERTAKER Jack Lewis | ADDRESS 1411 E Balto St

N.B.—Every item of information should be carefully supplied. Please write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Silber

D 54846

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54846

CERTIFICATE OF DEATH.

166

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1809 E Fairmont ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Sellers (Silber)

(Residence in Baltimore: No. 1809 E Fairmont ave Life St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): S

6-DATE OF BIRTH, Unknown (Month) (Day), 1913 (Year)

7-AGE, ... yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: ooo
(b) General nature of industry, business, or establishment in which employed (or employer): School

9-BIRTHPLACE (State or Country): Balto md

PARENTS.

10-NAME OF FATHER: Morris Silber

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Jannie Sandler

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Leurs

(Address) 1411 E Balto st

15- BOBERT & KRAUTER

FILED JUN 26 1921 191... Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Conflagration Burning building (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) H Ward Smalley M. D. (Coroner.)

..., 191... (Address) 4 Lake

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Workmen circle

DATE OF BURIAL, 6/27/21

20-UNDERTAKER, Jack Leurs

ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified, important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54847

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D 54847

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 Madison ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah Fine

(a) RESIDENCE. NO. 2026 Madison ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jacob B. Fine

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 E Baltimore St

15 Filed JUN 25 1921 Burial Permit

BOLLER & KRAUS

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to June 24, 1921, that I last saw h[illegible] alive on June 23, 1921, and that death occurred, on the date stated above, at 12:19 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Intestines
- with metastases

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 25, 1921

Was there an autopsy?

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) Samuel Solomon, M.D.

. 19 (Address) 1444 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehren Lauthers	6/26 19

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54848

CERTIFICATE OF DEATH.

1 20 D 54848

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1508 E Balto ST.; 7 WARD)

2-FULL NAME Seleg Levy

(a) RESIDENCE. NO. 1809 E Balto St ST., WARD. 17

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Levy

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1411 E Balto st

15 Filed JUN 26 1921, 19 ROBERT J. KRAMER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26 1921

17 I HEREBY CERTIFY, That I attended deceased from May. 14, 1921, to June 26, 1921,

that I last saw him alive on June 26, 1921,

and that death occurred, on the date stated above, at 10.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

Symptoms 3 months

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac. Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. Urine.

(Signed) Harold Sheets, M. D.

, 19 (Address) 927 N. Colvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	June 27 1921

20 UNDERTAKER Jack Lewis, 1411 E. Balto ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly ...k of certificates. ...TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54849

D 54849

CERTIFICATE OF DEATH.

37-091

REGISTERED NO. Mercy Hosp

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 620 Gilbert ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Casey

(a) RESIDENCE. No. 620 Gilbert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	negro	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Harry —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Dreay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Agnes Lemmon (Address) 620 Gilbert St.

15 Filed JUN 26 1921 ROBERT J. KRAUTEL Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from May 21 1921, to June 25, 1921, that I last saw her alive on June 25, 1921, and that death occurred, on the date stated above, at 5-40 A m.

The CAUSE OF DEATH* was as follows:

Congenital, Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? born with it

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Bl. Wasserman

(Signed) Francis A. Keaney, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery

DATE OF BURIAL 6/27 1921

20 UNDERTAKER H. Eli & Son

ADDRESS 1022 Mulberry St

mation should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54850

CERTIFICATE OF DEATH.

151 D 54850

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 N Green ST.; 4 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carmelo Serio

(Residence in Baltimore: No. 116 N. Green St.; ....yrs.,.... mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	

6-DATE OF BIRTH, 6 (Month) 23 (Day), 1921 (Year)

7-AGE, ...yrs.....mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City.

PARENTS.

10-NAME OF FATHER, Joseph Serio.

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Mary Prusi

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Serio

(Address) 116 N Green St

15- Filed JUN 26 1921, 191..... ROBERT J. BRAUTIGAM Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6 (Month) 25 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 6-23 1921, to 6-25 1921, that I saw h[illegible] alive on 6-25 1921, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Congenital debility

.....

.....

(Duration).....yrs.....mos. 3 ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) S. Damare M. D.

6-25, 1921 (Address) 1604 Linden Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
[illegible]	6.27, 1921
20-UNDERTAKER	ADDRESS
[illegible]	31 S Eighth St

CAUSES OF DEATH should be carefully and correctly stated. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54851

CERTIFICATE OF DEATH.

79

D 54851

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2135 E. Chase ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto L. Lautner

(Residence in Baltimore: No. 2135 E. Chase St.; 49 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Feb. 16, (Month) (Day) 1833. (Year)

7-AGE, 88 yrs. 4 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer 086
(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired 8 years

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Milton E. Buckman

(Address) 2135 E. Chase St

15- ROBERT J. KRAFFT

Filed JUN 23 1921 Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 25, (Month) (Day) 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 7 1921, to June 25 1921, that I saw h[im] alive on June 24 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) 1 yrs. ... mos. ... ds.

(Signed) H. E. Klemm M. D.

June 25, 1921 (Address) 3 W. Mt. Royal Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Long Green Balto Co. DATE OF BURIAL, June 27, 1921

20-UNDERTAKER A. S. Marshall ADDRESS 3759 Falls Rd

CAUSE OF DEATH must be stated plainly and fully. Every item should be answered. Do not use abbreviations or technical terms. Omission of important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 D 54852

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hospital (St.:) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah Ripley

(a) RESIDENCE. No. 1210 E. Federal St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Ripley

6 DATE OF BIRTH (month, day, and year) June 11, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER J. B. Joyce

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Beulah Pike

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Frank E. Ripley

(Address) 1210 E. Federal St

15 JUN 26 1921 ROBERT A. KRAUTER Registrar

Burial Permit Issued

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1921, to June 25, 1921, that I last saw h.e alive on June 25, 1921, and that death occurred, on the date stated above, at 5.15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ileum

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Hysterectomy with Surgical Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 22, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Raymond S. Abbott, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Camden N.J.	June 28 19
20 UNDERTAKER George D. Rudolph	ADDRESS [illegible]

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54853 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54853

CERTIFICATE OF DEATH. 137

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1816 Orleans ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Winder

(a) RESIDENCE. No. 1816 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife

6 DATE OF BIRTH (month, day, and year): May 12 1890

7 AGE: Years 30 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer): House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): born in Baltimore

PARENTS.

10 NAME OF FATHER: John H Travers

11 BIRTHPLACE OF FATHER (city or town) (State or country): born in Md

12 MAIDEN NAME OF MOTHER: Sarah Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): born in Dorchester Co Md

14 Informant: Alexander Winder (Address) 1816 Orleans St City

15 Filed JUN 26 1921 ROBERT I. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1921. to June 22, 1921.

that I last saw h[illegible] alive on June 21, 1921.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Puerperal peritonitis

Probable Intestinal "

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Incomplete abortion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno E Robinson M. D.

6/23 1921 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: June 26 1921

20 UNDERTAKER: Mrs R A Elliott — ADDRESS 1729 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be [illegible] of certificates. TION is very important. See instructions on back of cer

Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54854

D 54854

CERTIFICATE OF DEATH.

REGISTERED NO. C 106

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 N. Eutaw ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Edward Wheeler

(Residence in Baltimore: No. 922 N. Eutaw st St. Lapse, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. April 6th, 1919.
(Month) (Day) (Year)

7-AGE. 2 yrs. 2 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. James Wheeler

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Alice Pettigrew

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Wheeler

(Address) 922 N. Eutaw st

15-

Filed ....., 191.....

JUN 26 1921 Burial Permit

ROBERT E. KRAUTZ Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH June 23d, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 8 1921, to June 23 1921, that I saw h— alive on June 23d 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Toxic meningitis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Tonsilitis

(Duration) ....yrs. ....mos. ....ds.

(Signed) A. Fletcher Price M. D.

6 23 1921 (Address) 724 Mount St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Eldridge Landing Cem. DATE OF BURIAL, June 26 1921

20-UNDERTAKER Samuel Hunter ADDRESS 578 N. Gilmor

Consult your family physician in important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54855

CERTIFICATE OF DEATH.

28 D 54855

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 73 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Thomas J. Davern.

(a) RESIDENCE. NO. 1821 S. Charles. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinists 631

(b) General nature of industry, business, or establishment in which employed (or employer) B & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg, Va.

PARENTS

10 NAME OF FATHER James Davern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Nora Kirby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. Peters 1821 S. Charles

15 Filed JUN 26 1921 ROBERT I. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1921, to June 24, 1921, that I last saw him alive on June 24, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Pt's Bud. Symptoms.

(Signed) F. C. Mann. M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	6/28 1921
20 UNDERTAKER J. F. McCully	ADDRESS 131 E. Fort.

CAUSE OF DEATH in plain terms, avoiding use of abbreviations or technical terms. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54856

CERTIFICATE OF DEATH.

64

D 54856

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2324 Druid Hill Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Brown

(a) RESIDENCE. NO. 2324 Druid Hill Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Brown

6 DATE OF BIRTH (month, day, and year) June, 21, 1856,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Benjamin Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. City Md.

12 MAIDEN NAME OF MOTHER Elenor Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City Md.

14 Informant Wm. B. Brown
(Address) 2324 Druid Hill Ave.

15 Filed JUN 26 1921 ROBERT J. KRUG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to June 23, 1921, that I last saw her alive on June 23, 1921, and that death occurred, on the date stated above, at 9.05 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Henry F. Callenberg, M. D.

6/25. 1921 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	June 27, 1921
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. B. Co. 1000 Bks.

Dr. D. P. Alagia

D 54857

D 54857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3326 Fredrick Ave.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 N. Bentalou ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meta Tina Neuhaus

a) RESIDENCE. NO. 1103 N. Bentalou ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. F. H. Neuhaus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Gerdes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna C. Neuhaus

(Address) 1103 N. Bentalou St.

15 Filed JUN 26 1921 19 ROBERT J. KRAUTER Registrar

Burial permit Oked

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to June 24, 1921, that I last saw h[illegible] alive on June 24, 1921, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Following pulmonary Tuberculosis; Tuberculous peritonitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1103 Bentalou St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tuberculin test

(Signed) Samuel P. Alagia, M. D.

, 19 (Address) 3326 Fredrick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	June 27 1921
20 UNDERTAKER H. Sauder & Sons	ADDRESS 1700 Reed

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 54858

HEALTH DEPARTMENT—CITY OF BALTIMORE

43 D 54858

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2639 Greenmount ST., 9 WARD)

2-FULL NAME Elizabeth M. Hull

(a) RESIDENCE NO. 2639 Greenmount ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced, ~~HUSBAND~~ or (or) WIFE of Ira M. Hull

6 DATE OF BIRTH (month, day, and year) Oct 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	36	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Nicholas Muser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Dontknow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary.

14 Informant Ira M. Hull
(Address) 2639 Greenmount

15 Filed JUN 26 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 24th, 1921, to June 24th, 1921, that I last saw ~~him~~ her alive on June 24th, 1921, and that death occurred, on the date stated above, at 6.15 p. m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

Over

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. Longcope M. D. M. D.

6/27/1921 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery DATE OF BURIAL 6/27 1921

20 UNDERTAKER William Cook ADDRESS 502 E Nor.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54859

CERTIFICATE OF DEATH.

19

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Adams.

(a) RESIDENCE. NO. Hospital ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Adams

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Don't Know

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Robert A Adams

(Address) 320 N. Rose

15 Filed JUN 26 1921 ROBERT I KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1921, to June 27, 1921, that I last saw h alive on June 27, 1921, and that death occurred, on the date stated above, at 1230 m.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Post Symptoms

(Signed) Frank C Mason, M. D.

, 19 (Address) Hospital Physician

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 6/27 1921

20 UNDERTAKER Wm. Cook — ADDRESS Saratoga

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54860

CERTIFICATE OF DEATH.

92 D 54860

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 914 Little Pine ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Cross

(Residence in Baltimore: No. 914 Little Pine St.; 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	single

6-DATE OF BIRTH, November 1, 1879
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
42 yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Cross

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Freeman

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfonsia Cross

(Address) 914 Little Pine St.

15-

Filed JUN 26 1921 ROBERT I. [illegible]

Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

June 25, 1921. (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, June 27, 1921

20-UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Give full information as to important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54861

CERTIFICATE OF DEATH.

37 D 54861

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospitals, Bay View ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Scott

(a) RESIDENCE. NO. 608 Jasper St ST., WARD.

(Usual place of abode) Unknown

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE	Years	Months	Days	if LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: John Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Annie Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: Hospital Records,
(Address): New City Hospital.

15 Filed JUN 26 1921 ROBERT A. LEAUTH Registrar
Clerk

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1921 to June 22, 1921.

that I last saw h... in alive on June 22, 1921.

and that death occurred, on the date stated above, at 9:50 P.m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency - Cystic.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Ulyocardial insuffi ciency (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) R. E. Heerman. M. D.

6/23/21 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	June 26 1921
20 UNDERTAKER: Daniel Easton	ADDRESS 916 Bway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54862

D 54862

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1342 Carroll St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Tinson

(a) RESIDENCE. No. 1342 Carroll ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred all life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Tinson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of Industry, business, or establishment in which employed (or employer) General Household work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Ruffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raleigh N.C.

12 MAIDEN NAME OF MOTHER Mary Wallcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Eugene Ruffin (Address) 1342 Carroll st

15 Filed JUN 26 1921 ROBERT I. KRAUTH Registrar

Burial Permit Oliver

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1921, to June 23, 1921,

that I last saw her alive on June 22, 1921,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculer Peritonitis

(duration) ? yrs. ? mos. 45 ds. to my knowledge

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I don't Know

Did an operation precede death? No Date of ?

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D J Harroll M. D

, 19 (Address) 1400 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 26 1921
20 UNDERTAKER Daniel Easton	ADDRESS 916 Lo ne

CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54863

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 151 D 54863

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH On Lot. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. B 27th & Sisson ST.; 12 WARD)

2-FULL NAME Baby Nicholas

(a) RESIDENCE. NO. 27th & Sisson st ST., WARD. Delaware.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Whit-	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of May 24 — 1921

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER John Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Mary Catherine Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs Foler (Address) 27th & Sisson St

15 FILED JUN 26 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be used for statistical purposes; TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1921, to June 24, 1921, that I last saw h alive on June 24, 1921, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. A. Richardson M. D.

June 24, 1921 (Address) 1146 W. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magoth M E Cem

DATE OF BURIAL 6/26/21

20 UNDERTAKER E L Stiffler

ADDRESS 125 E Mt

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54864

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

D 54864

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Trapp Road near Fifth Ave. ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Dembek

(Residence in Baltimore: No. Trapp Road

S. W. 74 yrs. ..... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1 (Year)

7-AGE, 74 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Burzgarski.

(Address) Trapp Road near Fifth Ave.

15- Filed JUN 26 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

CAUSE OF DEATH to be plainly written, and every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1921, to June 25 1921, that I saw h.. alive on June 25 1921, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... yrs. Unknown

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) Frank J. Sampson M. D.

June 25, 1921. (Address) 2431 Fleet

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary Cem.

DATE OF BURIAL, June 28, 1921.

20-UNDERTAKER M. F. Sadowski.

ADDRESS 705 S. Ann St.

Bracki

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54865

CERTIFICATE OF DEATH.

67 D 54865

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1904 Allegheny St.; WARD)

2-FULL NAME Michael Borack.

(Residence in Baltimore: No. 1904 Allegheny St; St.: yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept 29, (Month) (Day) 1847 (Year)

7-AGE 73 yrs. 8 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Saw Saloon
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Frank Borack

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katharine Borack

(Address) 1904 Allegheny St.

15- ROBERT J. KRAUTER

Filed JUN 26 1921 Burial Permit issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hospitality

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Daniel Lynch M. D.

(Coroner) Coroner

June 27, 1921 (Address) 1004 Fallsway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus, Bal

DATE OF BURIAL, June 27" 1921.

20-UNDERTAKER W. F. Sadowski, ADDRESS 705 S. Ann St

N. B.—Every item of information must be given, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—4-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54866

CERTIFICATE OF DEATH

Raspeburg S. East. D. 5948613

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belair Road and Hamilton Ave. ST.; 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank R. Martin

(a) RESIDENCE. NO. S. E. Cor. Belair Road & Hamilton Ave ST., WARD. Raspeburg

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20th 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper 009

(b) General nature of industry, business, or establishment in which employed (or employer) Auto Body Factory

(c) Name of employer Max Martin Balto.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Max Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Max Martin (Address) Raspeburg Md.

15 Filed . 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

JUN 26 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1920, to June 25, 1921, that I last saw him alive on June 24 1921, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Mikenson, M. D.

6/25. 1921 (Address) Raspeburg, Balt, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	June 27 1921

20 UNDERTAKER Heath Lassalm & Sons ADDRESS Fullerton Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

54867

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 54867

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 N Arlington St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret V. Cunningham

(a) RESIDENCE. No. 1802 N Charles St.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home maker

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Catherine E. Smith
(Address) Roslyn Va

15 Filed JUN 26 1921 ROBERT I. KRAUTER, Registrar
Burial Permit Oiert

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 16 1920, to June 24 1921.

that I last saw h N alive on June 23 1921.

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 7 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

6/26 1921 (Address) 1823 N. Wash St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 27 1921
20 UNDERTAKER	ADDRESS
Robt Johnson	1X2 W Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 54868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54868

CERTIFICATE OF DEATH.

157

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2030 Hollins & Wood, ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Seibel

(Residence in Baltimore: No. 2030 Hollins St) St. (yrs. 55 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Aug. (Month) 11th (Day), 1844 (Year)

7-AGE, 76 yrs. 8 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 003
(b) General nature of industry, business, or establishment in which employed (or employer)..... Baker

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Frederick Seibel

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Hohmann

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa A Seibel

(Address) 2030 Hollins St

15- JUN 27 1921 ROBERT J KRAUTER

Filed ....., 191. Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation by Hanging Suicidal

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dependency

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H Fenlon M. D.
(Coroner.)

June 25. 1921 (Address) 700 E Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	June 27 1921
20-UNDERTAKER	ADDRESS
E Schlosman & Son	1034 Lanvale

N. B.—Every item of information should be given as far as known, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 54869

D 54869

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 E Oliver ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary O'Dea

(a) RESIDENCE. NO. 1003 E Oliver ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. — ds. How long in U. S., if of foreign birth? 41 yrs — mos — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Thomas P. O'Dea

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Mary E. O'Dea

(Address) 1003 E Oliver St

15 Filed JUN 27 1921 ROBERT I. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1921, to June 26, 1921, that I last saw h— alive on June 20, 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical

(Signed) James M Fenton, M. D.

6/24 1921 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 29 1921
20 UNDERTAKER Henry Hoock Son	ADDRESS 1201 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Any additional information may be given on back of certificates. See instructions on back. TION is very important.

Spmt.—6-9-19—H. P. Co.—1000 Blks.

D 54870

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54870

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (a) NO. 2218 W Fayette ST. 20 WARD)

2-FULL NAME Infant of Wm. H. and Rose Painter

(a) RESIDENCE. NO. 2218 W Fayette ST.. 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day 12 hrs. or min.
0				

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 600

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Wm. McPainter

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Rose Clark

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant William H. Painter
(Address) 2218 W. Fayette St

15 Filed JUN 27 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26 1921

17

I HEREBY CERTIFY, That I attended deceased from 6/25/21, 19 ..., to 6/26/21, 19 ...,

that I last saw him alive on 6/25/21, 19 ...,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth 6 mo Gestation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) By OMcCarty, M. D.

6/26, 1921 (Address) 400 N Bayson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	June 27 1921

20 UNDERTAKER Joseph B. Cook — ADDRESS 1013 N. Gallo St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

150 D 54871

D 54871

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 N Pulaski ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Wareken

(Residence in Baltimore: No. 525 N Pulaski St.: ....yrs.,....mos.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June 21, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. ....da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), 525 N Pulaski St

PARENTS.

10-NAME OF FATHER, Harry L Wareken

11-BIRTHPLACE OF FATHER (State or Country), Balto End

12-MAIDEN NAME OF MOTHER Birtie Bishop

13-BIRTHPLACE OF MOTHER (State or Country), Balto End

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Wareken

(Address) 525 N Pulaski St

15-Filed JUN 27 1921 191... ROBERT A KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 25th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 21st 1921, to June 25 1921, that I saw h.r alive on June 25 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Imperfect development

Marasmus

(Duration) ....yrs. 4 mos. ....da.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....da.

(Signed) W. T. Smith M. D.

June 25, 1921. (Address) 1184 Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park | DATE OF BURIAL, June 27, 1921

20-UNDERTAKER Ewald B Marker | ADDRESS 115 Elwood Ave

CAUSE OF DEATH in plain terms, as that it may be important. See instructions on back of certificate.

Burial Permit Issued

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 54872

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54872

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Genl Hos. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris E. Staff

(a) RESIDENCE. NO. 506 Ravenswood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 25-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				12 hrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George E. Staff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ella Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George E. Staff (Address) 506 Ravenswood

15 Filed JUN 27 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1921, to June 25, 1921, that I last saw h[illegible] alive on June 25, 1921, and that death occurred, on the date stated above, at 9-5 P. m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) yrs. mos. 12 hrs ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) R. W. Richardson, M. D.

, 19 (Address) Md Genl. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cem	6/27 1921
20 UNDERTAKER	ADDRESS
I. F. McCully	1305 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54873 D 54873

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 S. Hanover ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna A. Mitchell

(a) RESIDENCE. No. 1104 S. Hanover ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE ... TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Matthew Lyons Mitchell

6 DATE OF BIRTH (month, day, and year) Dec. 27, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Matron 086

(b) General nature of industry, business, or establishment in which employed (or employer) Charge of rest room in B&O. Bldg

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash., D. C.

PARENTS

10 NAME OF FATHER Michael Finerty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ella Mitchell

(Address) 1104 S. [redacted]

15 Filed JUN 27 1921 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to June 24, 1921, that I last saw h[illegible] alive on June 24, 1921, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

Mellitus

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [illegible] M. D.

June 26, 1921 (Address) 505 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 27 1921

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54874

CERTIFICATE OF DEATH.

120 D 54874

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Gilmor St ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Scofield

(a) RESIDENCE. NO. 523 N. Gilmor St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 17 1860

7 AGE: Years 61 Months 1 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School teacher

(b) General nature of industry, business, or establishment in which employed (or employer): 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md.

PARENTS

10 NAME OF FATHER: Alcinn Schofield

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Eliz. Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Eddland

14 Informant (Address): Mary L. Baker 523 N. Gilmor St

15 JUN 27 1921 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5th 1920, to June 25th 1921, that I last saw her alive on June 25th 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia 24 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) A. R. Lisle, M. D.

19 (Address) 614 N. Carrollton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: June 27 1921

20 UNDERTAKER: John Mitchell ADDRESS: 1201 W. Fayette

CAUSE OF DEATH—Fill in the blanks on back of certificate. See instructions on back of TION is very important.

Spec.--6-9-19--H. P. Co.--1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54875

D 54875

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4341 Harford Ave ST.; 57 WARD)

2-FULL NAME Olga Bierau

(a) RESIDENCE. NO. 4341 Harford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Bierau

6 DATE OF BIRTH (month, day, and year) June 22-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	57	0	01	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Lindberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER C. Diering

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Alexander Bierau
(Address) 2413 W. Lanvale St

15 Filed JUN 27 1921 [illegible]

Burial Permit Obtained

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug-25-1920, to June 26, 1921, that I last saw her alive on June 26, 1921, and that death occurred, on the date stated above, at 9. A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene right leg

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of no

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) E. Heller Hamming, M. D.

6/26 1921 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Bur	Jun 29 1921

20 UNDERTAKER F B Wolfgrat

ADDRESS 2236 Fredrick Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54876

CERTIFICATE OF DEATH.

104 D 54876

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 Light ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E Beall

(a) RESIDENCE. NO. 713 Light ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 15 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Beall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Elsie E Smoot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co Md

14 Informant Wm Beall
(Address) 713 Light St

15 Filed JUN 27 1921 ROBERT J. BRUCE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1921, to June 26, 1921, that I last saw h[illegible] alive on June 26 1921, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. E. Smith M. D.

, 19 (Address) 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	June 28 1921
20 UNDERTAKER	ADDRESS
John F Denny	715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or the back of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54877 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 54877

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 04 St. Morrell Pk. St.; 25 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna R. Loose

(Residence in Baltimore: No. 8th St. Morrell Park St.; 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Apr (Month) 14 (Day), 1853 (Year)

7-AGE, 68 yrs. 2 mos. 9 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Adam Lichtmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Loose

(Address) Morrell Pk.

15- JUN 27 1921 191.....

ROBERT J. KRAUTER

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jun (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jun 22 1921, to June 23 1921, that I saw h[illegible] alive on Jun 23 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic rheumatism
With endocarditis
myocarditis
four years

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart block

(Duration) ..... yrs. 7 mos. ..... ds.

(Signed) H. E. Kumpf M. D.

June 25, 1921. (Address) 1602 Hollander St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, June 27, 1921

20-UNDERTAKER Geo. Lewis Sons & Co. — ADDRESS 6 & N Bath

CAUSE OF DEATH to be plainly written, as much may depend upon it. All questions should be answered if possible, but those in italics are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Glonstedt

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54878

CERTIFICATE OF DEATH.

79 D 54878

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 653 Dover ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edw. Florstedt

(a) RESIDENCE. NO. 653 Dover ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Florstedt

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	—	—	—

8 OCCUPATION OF DECEASED 062

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Box Factory

(c) Name of employer Chas Furstenbaugh

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Edward Florstedt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Florstedt

(Address) 653 Dover St

15 Filed JUN 27 1921 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15 1921, to June 24 1921, that I last saw h[illegible] alive on June 23 1921, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ..... yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Dr. Geo. Boyd, M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 27 1921
20 UNDERTAKER	ADDRESS
Geo Lunt & Son	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54879

CERTIFICATE OF DEATH.

91-10D 54879

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 E. Madison ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Jaffe

(a) RESIDENCE. No. 1711 E. Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Abraham Jaffe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Kristka Land

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1711 E. Balto-St

15 Filed JUN 27 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to June 27, 1921, that I last saw him alive on June 27, 1921, and that death occurred, on the date stated above, at 730 A m.

The CAUSE OF DEATH* was as follows:

over

Acute endocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No test

(Signed) Jack Cohen, M. D.

6/27, 19 (Address) 2235 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Suburban Circle Mt. Carmel	June 27 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto-St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pericarditis ~~which~~ prior to endocarditis. Not diphtheretic.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54880

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2535 McCulloh ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Weinkrantz

(Residence in Baltimore: No. 2535 McCulloh St.; 6 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 46 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer) Department Store

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Bernard Weinkrantz

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Freda Rosenfeld

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm D Jacobson

(Address) Belvidere Apts

15- JUN 27 1921 ROBERT J. KRAUTER Registrar.

Filed ....., 191..

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended ~~deceased~~ last visit deceased from ....., 191..., to ....., 191...,
that I saw h~~im~~ alive on June 26 1921,
and that death occurred, on the date stated above, at 4 P.m.
The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
few minutes
(Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... da.

(Signed) E.K. Ballard M. D.
June 26 1921 (Address) Health Office

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence 2535 Mc Culloh St

19-PLACE OF BURIAL OR REMOVAL. Hebrew Washington Rd | DATE OF BURIAL. June 27 1921

20-UNDERTAKER Jos L Hunson | ADDRESS 1127 E Balto St

CAUSE OF DEATH must be plainly stated. Every question must be answered if possible. Omissions cause delay. Be careful and full in answering questions marked important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54881

CERTIFICATE OF DEATH.

32 D 54881

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospitals, Bay View ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Savoy

(a) RESIDENCE. NO. 223 Dolphin St ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Richard Savoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) New City Hospital.

15 Filed JUN 27 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from November 28, 1920 to June 24, 1921

that I last saw her alive on June 24, 1921

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Examination

(Signed) F A Holden, M. D.

6/24/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 27 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54882

CERTIFICATE OF DEATH.

D 54882

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5806 York Road ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fulton C Barrow

(Residence in Baltimore: No. 5806 York Road Life St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. Feb (Month) 22 (Day) 1873 (Year), / 1873

7-AGE. 47 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Jacob F Barrow

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary B Ensey

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Millie Barrow

(Address) 5806 York Road

15- JUN 27 1921 191 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemmorrage of prostate 7 days.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D. (Coroner.)

June 28, 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Johns Waverly	Jun 28/21 19....
20-UNDERTAKER	**ADDRESS**
Wm Cook	502 E Norr

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DR-MORRISSY. (ROLAND AVE)

Spec.—1-10-21—M&T—1500 Bks.

D 54883

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54883

CERTIFICATE OF DEATH.

81

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2615 Greenmount Ave (ST.) (WARD) 9

2-FULL NAME William H Parsons

(a) RESIDENCE No. 2615 Greenmount Ave WARD 9

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND (or) WIFE: Widowed Mary E Parsons

6 DATE OF BIRTH (month, day, and year): July 14 49

7 AGE: Years 76 Months 11 Days 14

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Edward Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Sarah Crayther

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Clara E. Lefferis 2615 Greenmount Ave

15 FILED JUN 27 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1918, to June 25, 1921, that I last saw h.m alive on June 25, 1921, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ---

(Signed) Edward Ades M. D.

6/24/21, 19 (Address) 32 E Pr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Ceme DATE OF BURIAL June 28 1921

20 UNDERTAKER: H E Padgett & Martha ADDRESS

Padgett 525 625 Ast

Information should be plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54884

CERTIFICATE OF DEATH.

1

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 550 Orchard ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Jones

(a) RESIDENCE. No. 550 Orchard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 27 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 040 General Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harriett Barrett (Address) 558 Orchard St.

15 Filed JUN 27 1921 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1921

17

I HEREBY CERTIFY, That I attended deceased from June 15 1921 to June 24 1921.

that I last saw him alive on June 24 1921.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Frank E. Wagner M. D.

1921 (Address) 1076 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, *Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	June 27 1921
20 UNDERTAKER James & Dennis	ADDRESS 1313 Pulaski

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54885

CERTIFICATE OF DEATH.

REGISTERED NO. 11 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Curtis

(a) RESIDENCE. No. 835 Linden Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory-worker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Mack Curtis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mamie Craig

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Hospital Records,
(Address) New City Hospital.

JUN 27 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 19 21

17 I HEREBY CERTIFY, That I attended deceased from May 2, 19 21, to June 24, 19 21, that I last saw her alive on June 24, 19 21, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopical test.

(Signed) [illegible] M. D.

6/24/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Laurel Cemetary	June 27 1921
20 UNDERTAKER	ADDRESS
Chas. O. Bailey	721 E. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MEDICAL CERTIFICATE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54886

CERTIFICATE OF DEATH.

X 79 D 54886

REGISTERED NO.....

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 14 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Blue (Emma) Blue

(a) RESIDENCE. NO. Box 144 Colgate ST.. WARD. Maryland

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? 43 yrs. 2 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
f.	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Blue

6 DATE OF BIRTH (month, day, and year) Apr 18-72

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Springfield Pa.

PARENTS

10 NAME OF FATHER Edward Mykell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Rebecca Hollis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant John Blue

(Address) German Hill Road Colgate

15 Filed JUN 27 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1921, to June 25, 1921.

that I last saw h.er alive on June 25, 1921.

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency; arteriosclerosis; hypertension.

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Colgate Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George B. Handy, M. D.

. 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	June 28 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

W 5547

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations may be used. Do not write on back of certificates. INFORMATION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 54887

D 54887

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 Falls Road ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edward Henry

(a) RESIDENCE. No. 228 Falls Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of — (or) WIFE of — Mary Martha Henry

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer D40

(b) General nature of industry, business, or establishment in which employed (or employer) Genl Laboring work

(c) Name of employer not given

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Abraham Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER not given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edw Henry (Address) 228 Fall Rd

15 Filed JUN 27 1921 19 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 1, 19 21, to June 25, 19 21.

That I last saw h[illegible] alive on June 25, 19 21.

and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation &
Decompensation

OVER

(duration), yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Came to stay

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dyspnea & Oedema

(Signed) Edw Short, M. D.

6/26/21 (Address) 1512 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL June 27 21

20 UNDERTAKER Samuel Hemsley ADDRESS 848 Madison

CAUSE OF DEATH in plain terms. So that it may be properly classified. Do not use abbreviations or the name of any disease as a cause of death, or mode of dying, such as heart failure, asthenia, etc., without adding the primary cause which produced it. Any additional facts which may explain the cause of death should be stated. See back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54888

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fenze Randall

(a) RESIDENCE. No. 508 Moores alley Balto md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy Lovett

6 DATE OF BIRTH (month, day, and year): 917 Druid Hill ave 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): S. Carolina

PARENTS

10 NAME OF FATHER: Simon Cannada

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. Carolina

12 MAIDEN NAME OF MOTHER: Katheryn Randall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. Carolina

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed ....., 19.... ROBERT J. KRAUTER Registrar

JUN 27 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1921, to June 24, 1921, that I last saw h~~im~~ alive on June 24, 1921, and that death occurred, on the date stated above, at 2.25 P. m.

The CAUSE OF DEATH* was as follows:

Rupture of aneurism

about (duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis (duration) Many yrs. mon. ds.

18 Where was disease contracted if not at place of death? Maryland

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) V. R. Mason, M. D.

6-25-21, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 27 1921
20 UNDERTAKER: Samuel Newsley	ADDRESS: [illegible]

IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54889

CERTIFICATE OF DEATH.

4/104 D 54889

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 656 Cider alley ST.; 4 WARD)

2-FULL NAME Robert Thompson

(a) RESIDENCE. NO. 656 Cider alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col-	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 4- 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Inf.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md-

PARENTS

10 NAME OF FATHER Mervin Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sophrina Brown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Virginia

14 Informant Sophrina Brown Mother
(Address) 656 Cider alley

15 Filed JUN 27 1921 19 ROBERT J. LEAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1921, to June 25, 1921, that I last saw him alive on June 25, 1921, and that death occurred, on the date stated above, at 12 5 a. m.

The CAUSE OF DEATH* was as follows:
Intestinal Indigestion

not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions & Heat

Weather (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? General Examination

(Signed) Samuel A Bair, M. D.

27 1921 (Address) 937 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 27 1921

20 UNDERTAKER Samuel Housley ADDRESS 5[illegible]

TION is very important. See instructions on back of certificates.

Spmc—6-9-19—H. P. Co.—1000 Bks.

D 54890

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54890

CERTIFICATE OF DEATH.

K 146

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General St. Hosp. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Koubek

(a) RESIDENCE. NO. Colonial Park. ST., Woodlawn WARD. Colonial Pk Woodlawn

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER James Koubek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Fuchs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant James Koubek

(Address) Colonial Pk

15 Filed JUN 27 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17

I HEREBY CERTIFY, That I attended deceased from June 22, 1921, to June 26, 1921, that I last saw h/ alive on June 24, 1921, and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Acute Osteomyelitis of Right Tibia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) yrs. mos. 1 ds.

If Where was disease contracted if not at place of death? at residence

Did an operation precede death? Yes Date of 6/25/21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Wm. Fahey Lumpkin M. D.

, 19 (Address) Maryland General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	June 28 1921
20 UNDERTAKER	ADDRESS
Frank Cracknell Son	1914 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be understood by persons not physicians. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Tavik

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54891

CERTIFICATE OF DEATH.

40 D 54891

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1500 N Collington Ave ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary B Tavik

(a) RESIDENCE. NO. 1500 N Collington Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? 81 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Mulatto

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles J. Tavik

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 41; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Mathy Zeman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Charles Tavik
Address: 1500 N Collington Ave

15 Filed JUN 27 1921 ROBERT J. FRAZIER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1921, to June 24, 1921, that I last saw h[illegible] alive on June 24, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Kerr M. D.

6/27/21, 19 (Address) 1001 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill — DATE OF BURIAL: June 27 1921

20 UNDERTAKER: Frank Enoch & Son — ADDRESS: 1106 Eutaw

CAUSE OF DEATH in plain terms. [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48 D 54892

REGISTERED NO.

D 54892

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #412-W-Saratoga Street St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Paddington Aler.

(a) RESIDENCE. NO. #412-W-Saratoga-Street St. 4 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? 81 yrs. 9 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Reuben J. Aler.

6 DATE OF BIRTH (month, day, and year): Aug-27-1839.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Edward Paddington

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? ? ? England.

12 MAIDEN NAME OF MOTHER: Isabel ? ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North part of Ireland.

14 Informant (Address): Dr. Willis W. Aler (son) 412-W-Saratoga-St.

15 Filed JUN 27 1921 ROBERT J. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1921

17 I HEREBY CERTIFY, That I attended deceased (from) Jan 1, 1918, to June 24 1921.

That I last saw her alive on June 24, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary): Arthritis Deformans

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Joanna C. Agnew, M. D.

, 19 (Address) 3640 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: June-27-21

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or initials. Name of contagious disease must be given. Omission to state the time at which deceased was attended during last illness, and the time at which death occurred, is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

137 D 54893

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W. Agnes Hosp. ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Olie Linall

(a) RESIDENCE. No. Savage Md. ST., WARD. Savage Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos 1 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
age. 27				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Sills.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Olie Sealock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) George E. Linall. Linall Md.

15 Filed JUN 27 1921 ROBERT I. KRAUTZ Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1921, to June 26, 1921.

That I last saw h-- alive on June 26, 1921,

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal sepsis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pelvic peritonitis (duration) yrs. mos. ds. and peritonitis

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 26-21

Was there an autopsy? No.

What (est confirmed diagnosis? Smears & cultures

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Savage Md.	6/27/1921

20 UNDERTAKER ADDRESS

George E. Linall Linall Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. ~~Either~~ the mode of DEATH or the DISEASE CAUSING DEATH may be given, but both should be stated if known. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54894

CERTIFICATE OF DEATH.

120 D 54894

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Pennsylvania Ave. WARD 70)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Mears

(a) RESIDENCE. NO. 1906 Pennsylvania Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 30 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas G. Mears

6 DATE OF BIRTH (month, day, and year): July 11 - 1869

7 AGE — Years: 52 — Months: 11 — Days: 13 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: Frank Cass

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Barbra Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co Md

14 Informant (Address): Raymond A. Galloway 1906 Pennsylvania Ave

15 Filed JUN 27 1921 ROBERT J. KRAETER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1921, to June 24, 1921, that I last saw her alive on June 24, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted? —

If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Thompson M. D.

(Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 28 1921
20 UNDERTAKER: Robert Brockerson	ADDRESS: CALHOUN HOLLINS ST

CAUSE OF DEATH in plain terms. Indefinite or unknown causes of death are not sufficient. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54895

CERTIFICATE OF DEATH.

107

D 54895

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 S. Ann St. ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Markos

(a) RESIDENCE. No. 617 S. Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 25-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Markos

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Anna Guski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Michael Markos
(Address) 617 S. Ann St.

15 FILED JUN 27 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17 I HEREBY CERTIFY, that I attended deceased from June 21, 1921, to June 26, 1921,
that I last saw h... alive on June 26, 1921,
and that death occurred, on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:

Entero Colitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Gosner, M. D.

June 29 1921 (Address) 801 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	June 27 1921
20 UNDERTAKER Lilly & Zeile	ADDRESS 403 S. Wolfe

TION is very important. See instructions on

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 64 D 54896

REGISTERED NO. C

D 54896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 N. Fremont ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie B. Lauterbach

(Residence in Baltimore: No. 211 N. Fremont Ave (Visiting) St.; ..... yrs., ... mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Aug. (Month) 27 (Day), 1855 (Year)

7-AGE. 65 yrs. 10 mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country) Carroll Co. Md.

PARENTS.

10-NAME OF FATHER. Kennard Hampden

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Elizabeth Grayson

13-BIRTHPLACE OF MOTHER (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. F. Koller

(Address) Sykesville Md.

15- JUN 27 1921 Filed ..... 191.. ROBERT J. KRAUTER Registrar

Burial in Westminster

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 18 1921, to June 26 1921, that I saw h[illegible] alive on June 26 1921, and that death occurred, on the date stated above, at 12-0 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) O. M. Duvall M. D.

June 26, 1921 (Address) 1817 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 10 ds. In the State Life mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Freedom, Md

19-PLACE OF BURIAL OR REMOVAL, Westminster Md

DATE OF BURIAL, June 30 1921

20-UNDERTAKER James R. Shea

ADDRESS Sykesville Md

Cross out any word not important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 54897

D 54897

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 E. Madison ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Grant

(a) RESIDENCE. No. 1503 E. Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-22-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wesley Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elenora Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Elenora Grant
(Address) 1503 E. Madison

15 Filed JUN 27 1921 ROBERT P. LAMOTTE Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-24- 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-22-, 1921, to 6-24-, 1921, that I last saw h.im alive on 6-23-, 1921, and that death occurred, on the date stated above, at 1,30 m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M D Gaynell M. D.

6-24 1921 (Address) 611 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	JUN 25 1921 19
20 UNDERTAKER Commissioner Health.	ADDRESS

Rec. Wm. E. WOODALL.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54898

CERTIFICATE OF DEATH.

151 D 54898

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 29-8th St. (Fairfield ST.) 25 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Cunningham

(a) RESIDENCE. NO. 29-8th St, Fairfield ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) May 30/21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairfield, Balto, Md

PARENTS

10 NAME OF FATHER Charles Augustus Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fairfield Md

12 MAIDEN NAME OF MOTHER Annie O. Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md

14 Informant Charles A. Cunningham (Address) 29-8th St. Fairfield

15 Filed ..... 19 ..... Registrar

JUN 27 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to June 25, 1921, that I last saw h.. alive on June 24, 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Congenital debility

(duration) ... yrs. ... mos. 26 ds.

CONTRIBUTORY (Secondary) premature birth (7 mos)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Not Asked

(Signed) H. Bascom Slemp, M. D.

6/25 1921 (Address) 211 Church St, Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
HOPKINS HOSPITAL	
20 UNDERTAKER Commissioner Health.	ADDRESS JUN 25 1921

ROBERT B. KRAUS

Burial [illegible] Clerk

15273

E. M. WOODALL

CAUSE OF DEATH. Name place of disease. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54899

CERTIFICATE OF DEATH.

40 D 54899

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wilson

(a) RESIDENCE. NO. ..... ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Joshua Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Mary Ann Traay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant (Address) Hospital Record, New City Hospital

15 FILED JUN 27 1921 ROBERT J. KRAUTH Registrar

Burial Permit Clock

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1921 to June 23 1921.

that I last saw him alive on June 22, 1921.

and that death occurred, on the date stated above, at 6:45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No No special test.

What test confirmed diagnosis?

(Signed) [illegible] Patterman, M. D.

6/23/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND.

DATE OF BURIAL JUN 27 1921

20 UNDERTAKER

ADDRESS

Commissioner Health.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54900

D 54900

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 Monland Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgie Davis Warrington

(a) RESIDENCE NO. 1821 Monland ST., WARD.
(Usual) place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	M	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 7-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bells Haven Va

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliz. Mears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant W. S. Norrington
(Address) 1821 Monland Ave

15 Filed JUN 27 192 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1920, to June 26, 1921, that I last saw her alive on June 25, 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis (senile) with gradual failure due to age and heat,

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Probably influenced by heat wave, (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Wesley Cole, M. D.

19 (Address) 1207 Gorsuch,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Passavador Cemetery Co. | DATE OF BURIAL: June 28th 1921

20 UNDERTAKER: Bertram Cole | ADDRESS: 1233 N. Gilmor St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificates of DEATH must be filed with the Registrar of the district in which death occurs before a burial permit will be issued. See reverse side for additional instructions. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54901

CERTIFICATE OF DEATH.

D 54901 - 64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 Warwick Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winnie Ellsworth Flaggs.

(a) RESIDENCE. NO. 1738 Warwick Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Flaggs

May 15th, 1862

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Yonkton Md.

PARENTS

10 NAME OF FATHER Thomas S. Rosier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriett Parsons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Charles A Flagge 1738 Warwick Ave

15 Filed JUN 27 192 [illegible] Registrar

Burial Permit Check

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, that I attended deceased from July 10 . 1919 . to June 27 . 1921.

that I last saw h[illegible] alive on " 27 . 1921.

and that death occurred, on the date stated above, at 2:40 A.M.

The CAUSE OF DEATH* was as follows:

apoplexy -

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no -

What test confirmed diagnosis?

(Signed) L. T. Melvin M. D.

, 19 (Address) 1303 W. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: June 29 1921

20 UNDERTAKER [illegible] ADDRESS 1520 N Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement may be of importance. See instructions on back of certificates.

D 54902 HEALTH DEPARTMENT—CITY OF BALTIMORE. ✓ D 54902

CERTIFICATE OF DEATH.

REGISTERED No. C 15 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2933 Walbrook Ave ST. 15 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E. Rentch

(Residence in Baltimore: No. 2933 Walbrook ave. St.; 11 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, April (Month) 20 (Day), 1850 (Year)

7-AGE,	If LESS than 1 day,
71 yrs. 2 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Government Clerk

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Daniel Rentch

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Shoemaker

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie E. Rentch

(Address) 2933 Walbrook Ave.

15- Robert F. Harrison, Registrar.

JUN 27 1921 ....., 191.....

Burial Permit Clerk

B & O. R.R. to Milton, Pa. Private.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage, primary

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) and history

(Duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy M. D. (Coroner.)

June 27, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Shenandoah June DATE OF BURIAL, June 29 1921

20-UNDERTAKER Wm Cook ADDRESS 502 E. N. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 54903 — 64 54903

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 445 E. 25th St., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria C. Bartholow

(Residence in Baltimore: No. 445 E. 25th St. St.; 72 yrs. 9 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6-DATE OF BIRTH Sept (Month) 20 (Day) 1848 (Year)

7-AGE 72 yrs 9 mos 7 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country) Maryland

PARENTS

10-NAME OF FATHER James Nelson

11-BIRTHPLACE OF FATHER (State or country) Ireland

12-MAIDEN NAME OF MOTHER Mary E Cain

13-BIRTHPLACE OF MOTHER (State or country) Harford Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas F Carey

(Address) 445 E. 25th St.

15-

Filed ..... Robert P. Harrison ..... REGISTRAR

6/27/1921 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June (Month) 27 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January, 1921, to June 27 1921, that I saw her alive on June 26 1921, and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs ..... mos 3 ds

Contributory (SECONDARY) Cancer (Duration) ..... yrs ..... mos 2 ds

(Signed) C. F. Bouchelle M.D.

6/27 1921 [Address] 2104 St. Paul St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: 6/30 1921

20-UNDERTAKER: Chas F Evans & Son — ADDRESS: 118 N. Mt. Royal Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements TION is very important. See instructions on back of certificate.

D 54904

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 ✓ D 54904

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 Eaton Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Barron Putts

(Residence in Baltimore: No. 822 Eaton Ave St.: 64 yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: November 1 (Month) (Day) (Year)

7-AGE: Above 60 yrs. mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE (State or country): Balto. Md

PARENTS

10-NAME OF FATHER: John Barron

11-BIRTHPLACE OF FATHER (State or country): Massachusetts

12-MAIDEN NAME OF MOTHER: Eliza Brace

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucia Putts

(Address) 822 Eaton Ave

15- Filed ..... 191.....

Robert P. Harrison, Registrar

Burial Permit Clerk

N 27 1921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1921, to, June 27 1921, that I saw her alive on June 26 1921, and that death occurred, on the date stated above, at 3.30 p.m.,

The CAUSE OF DEATH* was as follows:

Uraemic Coma following Chronic Nephritis

(Duration) 4 yrs mos ds.

Contributory (SECONDARY) Carcinoma of Pancreas

(Duration) 2 yrs mos ds.

(Signed) Dr. E. [illegible] M. D.

June 27, 1921 [Address] 720 St. Paul St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount

DATE OF BURIAL: June 28 1921

20-UNDERTAKER: W. F. Sudworth Son

ADDRESS: Northern

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. of Hom

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 54905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54905

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 N. Smallwood ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anna Graham

(a) RESIDENCE. No. 1813 N. Smallwood ST. 15 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Graham

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58		—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) 100
(c) Name of employer

9 BIRTHPLACE (city ~~or town~~) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William Stevens

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Maria Burke

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Sadie Graham
(Address) 1813 N. Smallwood St.

15 Robert P. Harrison, Registrar

N 27 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 26, 1921, that I last saw her alive on June 26, 1921, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) yrs. 5 mos. 26 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uremia & Coma

(Signed) August Hoene, M. D.

, 1924 (Address) 406 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 29 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	827 W. North Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 54906

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 ✓ D 54906

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: No. ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice E. Smith

(a) RESIDENCE. NO. 736 Harford Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Harry Smith

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress. 041

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Bay View Hospital Balto, Md.

15 Filed Robert P. Harrison, Registrar

27 1921 Burial Permit Cl[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1921

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1921, to June 23, 1921.

that I last saw h[illegible] alive on June 23, 1921.

and that death occurred, on the date stated above, at 8-30 P. m.

The CAUSE OF DEATH* was as follows: OVER

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Mania & Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. Fredericksmith M. D.

6/24/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arlington Station Va — DATE OF BURIAL: July 27, 1921

20 UNDERTAKER: Mrs Robert A Elliott — ADDRESS: 1725 Ashland Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history. Not luetic. Not tuberculous.

Spec.—6-9-19—H. P. Co.—1000 Bks.

149070
D 54907

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54907

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Horning

(a) RESIDENCE. No. 1021 Bayard St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mamie Horning - wife

6 DATE OF BIRTH (month, day, and year) Nov. 13. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Julius Horning.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Gleitenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed Robert P. Harrison, Registrar

N 27 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 24, 19 21, to June 27, 19 21, that I last saw h.. alive on June 27, 19 21, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Terminal acute fibrinous pericarditis
(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, hypertension, chronic nephritis (duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto -

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) V. R. Mason, M. D.

6-27-21 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	6-29 1921
20 UNDERTAKER William Cook	ADDRESS 502 E Mt St

CAUSE OF DEATH must be given in plain terms. No abbreviations or technical words may be used. Do not state mode of dying, as shock or heart failure, but what caused shock or heart failure. Indefinite or incomplete answers cannot be accepted. Neglect of this precaution may cause delay in burial of the body and in the issuance of certificates. ATTENTION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54908

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Municipal tuberculosis Hospital ST. 18 WARD.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley Hopkins

(a) RESIDENCE. No. 28 N. Appleton St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widower

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of Widowed.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
80.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West River Maryland

PARENTS

10 NAME OF FATHER Bill Hopkins.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah Johnson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Wilson Marshall 331 ~~[illegible]~~ Stricker St

15 Filed N 27 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1921, to June 26, 1921, that I last saw ~~him~~ alive on June 26, 1921, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Tuberculosis pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of ——

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum.

(Signed) L. J. Rigney, M. D.

6-26-21, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 28 1921
20 UNDERTAKER	ADDRESS 1140
Brown & Holland	Schroeder St

D 54909 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54909

CERTIFICATE OF DEATH.

119 REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2114 Boyd ST. 20 WARD)

2-FULL NAME Kenneth Thomas

(Residence in Baltimore: No. 2114 Boyd St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 15, (Day) 1915 (Year)

7-AGE, 5 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) good

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, William J. Thomas

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Margaret Kilton

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J. Thomas

(Address) 2114 Boyd St.

15- Robert P. Harrison,

Filed....., 191.... Registrar.

N27 1921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 7 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Nephritis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James H. Fenton M. D. (Coroner.)

June 27 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Rolen Rc

DATE OF BURIAL, June 28. 1921.

20-UNDERTAKER Geo L. Lohmeyer & Bro

ADDRESS 2101 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10 21 M&T 1500 Bks.

D 54910 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54910

CERTIFICATE OF DEATH. X 73

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nr 1 East Preston ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Cornish

(a) RESIDENCE NO. Nr 1 E. Preston ST., WARD Chicago Ill.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Albert Smyth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Can

12 MAIDEN NAME OF MOTHER Elizabeth Nisbet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Can

14 Informant F. D. DeLynn
(Address) Nr 1 E. Preston St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, that I attended deceased from May 29th, 1921, to June 25, 1921, that I last saw h[illegible] alive on June 25, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
Neuritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Blood test

(Signed) John F. Logan M. D.

19 (Address) 76 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 29 1921

20 UNDERTAKER: Wm Cook — ADDRESS: [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 27 1921

Spec.—8-24-14—M. & T.—2000 Bks.

D 54911 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54911

CERTIFICATE OF DEATH.

REGISTERED NO. C 1527

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 S Hulton av ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Edgar N & Annie Gearhardt

(Residence in Baltimore: No. 628 S Hulton av St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	W	S

6-DATE OF BIRTH, June (Month) 7 (Day), 1921 (Year).

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 7 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) 880

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Edgar N Gearhardt

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Annie Rehmert

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E N Gearhardt

(Address) 628 S Hulton av

15-

Filed ..... 191 ..... Robert P. Harrison, Registrar.

JUL 7 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 27 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from June 7 1921, to June 7 1921, that I saw him alive on June 7 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows: Child born without an attendant Mother had not been under the Physicians Care Child lived Instantly Died of Death (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity about 8 mo child (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. E. Dumas M. D.

June 27 1921 (Address) 1520 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral DATE OF BURIAL, June 28 1921

20-UNDERTAKER Wm Ebel ADDRESS 502 E North Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54912

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View ST.) 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Kramer.

(a) RESIDENCE. NO. 241 S. Stricker ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Maryland.

PARENTS

10 NAME OF FATHER David Joiner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah Snead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records. (Address) City Hospital Bay View

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1921, to June 26, 1921.

that I last saw her alive on June 26, 1921.

and that death occurred, on the date stated above, at 4 45 m.

The CAUSE OF DEATH* was as follows:

Auricular fibrillation

(duration) 2. yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) V B Stevenson, M. D.

6-26, 1921 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hall Md	June 28 1921

20 UNDERTAKER Wilbur H Shriver. ADDRESS 1018 Edmondson Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 27 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54913

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 Mt. Royal Ave. ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Naomi Whalen

(a) RESIDENCE. No. 1204 Mt. Royal Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(if nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 7-1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER David F. Whalen

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Mayomi Wolfe

13 BIRTHPLACE OF MOTHER (city or town) Hagerstown Md (State or country)

14 Informant David F. Whalen

(Address) 1204 Mt. Royal Ave

15 Filed ..... 19 Robert F. Harrison, Registrar

Burial Permit Clerk

271921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to June 27, 1921, that I last saw her alive on June 27, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(all names)

about (duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Block

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) H. C. Kerkwith M. D.

6/27, 1921 (Address) 1032 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	June 29 1921
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave

CAUSE OF DEATH IS plain terms, so that no abbreviations or symbols are used. Do not write on this line. Write on back of certificates. TION is very important. See instructions on

D 54914 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54914

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 169

CITY OF BALTIMORE (No. Foot of Lawrence St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rudolph Karasek.

(Residence in Baltimore: No. 1206 Towson St. St.: 2 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH. June 4th. 1913., 1 (Month) (Day) (Year)

7-AGE. 8 yrs. 0 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Hungary.

PARENTS.

10-NAME OF FATHER. Charles Karasek.

11-BIRTHPLACE OF FATHER (State or Country). Bohemia.

12-MAIDEN NAME OF MOTHER. Irene Toth.

13-BIRTHPLACE OF MOTHER (State or Country). Hungary.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Karasek. (father)

(Address) 1206 Towson St.

15- Filed JUN 28 1921 191 ROBERT J. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 26th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally drowned by falling into the water while at play.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto F. Reinhardt M. D. (Coroner)

June, 28. 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	June 28. 1921
20-UNDERTAKER. Frank L. Wadsworth	ADDRESS 1906 Eastlond Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 54915

HEALTH DEPARTMENT—CITY OF BALTIMORE

181 MD 54915

CERTIFICATE OF DEATH.

REGISTERED NO. C

1 PLACE OF DEATH Balto. Tube Works

CITY OF BALTIMORE (No. Wisconsin & Orkney ST. 73 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Jesse Spriggs

(Residence in Baltimore: No. 136 W. Hamburg St.: yrs. mos. ds.)

n/a

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	colored	Single

6-DATE OF BIRTH, Nov (Month) 15 (Day), 1883 (Year)

7-AGE, 37 yrs. 8 mos. 10 ds. If LESS than 1 day, ...hrs. or....mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Tube Works

9-BIRTHPLACE. (State or Country): Balto City.

PARENTS.

10-NAME OF FATHER: Sutton Spriggs

11-BIRTHPLACE OF FATHER (State or Country): Balto. City

12-MAIDEN NAME OF MOTHER: Mary Cooper

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Spriggs

(Address) 136 W Hamburg St

15- Filed JUN 28 1921, 191.... ROBERT J KRAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocution by Coming in Contact with live wire while at work. Accident

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) James M Fenton M. D. (Coroner.)

June 27, 1921. (Address) 110 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State .... yrs. ....mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Olivet Cemetery

DATE OF BURIAL. June 28, 1921

20-UNDERTAKER R. S. Parham,

ADDRESS 341 W. Lee St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54916

CERTIFICATE OF DEATH.

79 ✓

D 54916

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2302 E. Baltimore St.; 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Nelson Marquette

(a) RESIDENCE. No. 2319 E. Biddle St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Catherine A. Marquette

6 DATE OF BIRTH (month, day, and year) May 9. 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER: Stephen Marquette

11 BIRTHPLACE OF FATHER (city or town) (State or country): Atlanticc Ocean America

12 MAIDEN NAME OF MOTHER: Mary Bosley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: James Marquette

(Address): 3005 McElderry St.

15 Filed JUN 28 1921 ~~MOSBY & BROTHER~~ Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1919, to June 27, 1921, that I last saw h[illegible] alive on June 26, 1921, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Pierce, M. D.

June 27 19 21 (Address) 234 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	6-29-21 19

20 UNDERTAKER: H.E. Hughes ADDRESS: 424 N. Broadway

D 54917

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 54917

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 539 n Lakewood St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.))

2-FULL NAME Mary M. McGowan.

(Residence in Baltimore: No. 539 n Lakewood St.; yrs. 7 mos. dys.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col'd	Widow

6-DATE OF BIRTH, August (Month) 29 (Day), 1865 (Year)

7-AGE, 55 yrs. 9 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Grace

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Bond

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W.J.McGowan

(Address) 539 N.Lakewood Ave

15- Filed JUN 28 1921 Burial Permit Given

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Chronic Indurative Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Signed (Coroner) M. D.

6-27-21, 19.. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt.Carmel Cemetery	6-28-21 19....
20-UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54918

CERTIFICATE OF DEATH.

44 D 54918

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View. WARD 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Jones

(a) RESIDENCE. NO. 2908 McElderry St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co., Maryland

PARENTS

10 NAME OF FATHER George Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co., Maryland

12 MAIDEN NAME OF MOTHER Francis Usselton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co., Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JUN 28 1921 BOARD OF HEALTH REPORT Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1921. to June 26. 1921. that I last saw her alive on June 26. 1921. and that death occurred, on the date stated above, at 2:00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Face

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia & Cachexia (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. A. Holden M. D.

6/27/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Colchester Md DATE OF BURIAL 6/28 1921

20 UNDERTAKER William Cook ADDRESS 502 E Nott

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54919

CERTIFICATE OF DEATH.

40 D 54919

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Parkin st ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Hancke

(a) RESIDENCE. NO. 108 Parkin ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Hancke

6 DATE OF BIRTH (month, day, and year): Nov 23 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Anton Glatzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Adolph Hancke
(Address): 108 Parkin

15 Filed JUN 28 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1st, 1921, to June 25, 1921, that I last saw h[illegible] alive on June 25, 1921, and that death occurred, on the date stated above, at 9 7 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) C. Blenton M. D.

6/27 1921 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westen Cemetery — DATE OF BURIAL: 6/28 1921

20 UNDERTAKER: George A Fahey — ADDRESS: Fulton & Fayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54920

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 54920

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. (Municipal Tuberculosis Hospital St. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Dowder

(a) RESIDENCE. No. 804 E. Pratt st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Thomas Dowder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hospital Records
(Address) M.T.H.

15 FILED JUN 28 1921 ROBERT E KRAUTER Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1921, to June 26, 1921, that I last saw him alive on June 26, 1921, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Abscess of lung

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings.

(Signed) [signature], M. D.

6-27-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	June 29 1921
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S. Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 54921

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2567 Greenmount Ave. WARD 9)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Connolly.

(a) RESIDENCE. (No. 2567 Greenmount Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 25/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Francis Connolly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Blaulby.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Francis Connolly.
(Address) 2567 Greenmount Ave.

15 Filed JUN 28 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-27 1921.

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1921, to June 27, 1921, that I last saw h. alive on June 27, 1921, and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) — yrs. — mos. 1/2 ds.

CONTRIBUTORY (Secondary) Hem. Colitis Patent Heart Valve.

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) G. J. Roberts. M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 28 1921
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54922 D 54922

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2315 Morris ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Jones

(Residence in Baltimore: No. 2315 Morris St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, ...(Month) ....(Day) 1836 (Year)

7-AGE. 85 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE. (State or Country) Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Wilson

(Address) 2315 Morris

15- Filed JUN 28 1921 191.... Registrar. ROBERT L. KRAUSE Clerk Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 25 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I ~~attended~~ deceased from June 25 1921 to June 25 1921, that I saw him alive on June 25 — 1921, and that death occurred, on the date stated above, at 10.2 p.m.

The CAUSE OF DEATH* was as follows: Chronic Valvular heart disease

(Duration) unknown yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. T. Coleman M. D.

June 25, 1921 (Address) 2357 McCulloh St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL. National Cemetery

DATE OF BURIAL, June 28, 1921.

20-UNDERTAKER Edward Pringle

ADDRESS 1463 Carey St

CASE OF DEATH in plain terms, so that it may be properly classified. Every statement of occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54923

CERTIFICATE OF DEATH.

42 D 54923

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3013 W.McElderry ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Barton

(a) RESIDENCE. No. 3013 McElderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? 50 yrs. 2 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced (HUSBAND) of (or) (WIFE) of Oscar Barton

6 DATE OF BIRTH (month, day, and year) May 13-71

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Albert Leinkuhler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Lena —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Oscar Barton (Address) 3013 McElderry St

15 Filed JUN 28 1921 ROBERT B. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1920, to June 26, 1921 that I last saw h[illegible] alive on June 25, 1921 and that death occurred, on the date stated above, at 3:15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) F. J. Langrehr, M. D.

6-27-21 (Address) 1000 N. Oak St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	June 28 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 54924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 W Franklin ST.: 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Grinage

(Residence in Baltimore: No. 830 W. Franklin st St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Blk	Married

6-DATE OF BIRTH, April (Month) 14 (Day), 1900 (Year)

7-AGE, 21 yrs. 2 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm Humphrey

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Jane

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Johnson

(Address) 1432 Dol. Court

15- Filed JUN 28 1921, 191... Burial permit issued

ROBT. J. BRUCE, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 24 1921, that I saw her alive on June 23 1921, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

Several

months (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John F. Munger M. D.

, 191... (Address) 1005 E. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem DATE OF BURIAL, June 27 1921

20-UNDERTAKER Chas. B. Reus ADDRESS 1300 E. Fayette

CAUSE OF DEATH must be plainly written, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54925

151-091

CERTIFICATE OF DEATH.

D 54925

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital ST.; 4 WARD)

2-FULL NAME Silvia Davis

(a) RESIDENCE. NO. 635 Calvert St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 7 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Silvia Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant (Address)

15 Filed JUN 28 1921 ROBERT B. REACH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7. 1921. to June 25. 1921. that I last saw h[illegible] alive on June 25. 1921. and that death occurred, on the date stated above, at 3 50 A m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis T. Kearney, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS JUN 28 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JOHNS HOPKINS HOSPITAL Commissioner Health.

D 54926

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

154 D 54926

(PLACE OF DEATH) REGISTERED NO. C

CITY OF BALTIMORE (No 1210 W Lanvale ST. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Martha D Tileston

(Residence in Baltimore: No. 1210 W Lanvale St ST.; 84 yrs. 2 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~ (Write the word): Single

6 DATE OF BIRTH: March 29, 1837 (Month) (Day) (Year)

7 AGE: 84 yrs. 2 mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer): None 000

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm. Tileston

11 BIRTHPLACE OF FATHER (State or country): Boston Mass

12 MAIDEN NAME OF MOTHER: Martha Marsden

13 BIRTHPLACE OF MOTHER (State or country): Boston Mass

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John H. Baughman

(Address) 1210 W. Lanvale St

15 Filed JUN 28 1921 ~~BURIAL PERMIT~~ Burial Permit Issued REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 27th (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24th, 1921, to. June 27th 1921, that I saw h[illegible] alive on June 27th, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia disease the direct
from exhaustion of age, and
Exhaustion from the heat of the weather

(Duration) ..... yrs. 2 mos. 3 ds

Contributory (SECONDARY) Extreme heat of the day

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed). John J Remington M. D.

June 28, 1921 (Address) 1526 Bolton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Greenmount — DATE OF BURIAL: June 30, 1921

20 UNDERTAKER: Geo W Little — ADDRESS: 3700 Edmondson Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54927

CERTIFICATE OF DEATH.

175-08

D 54927

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph M. Bauer

(Residence in Baltimore: No. Belleview ave Raspberry. St.; 48 yrs., 2 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word) Married

6-DATE OF BIRTH, March 14, 1873
(Month) (Day) (Year)

7-AGE, 48 yrs. 7 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Gardner
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER John D. Bauer

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Margaret Schumaw

13-BIRTHPLACE OF MOTHER (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Anna M. Bauer

(Address) Belleview & Raspberry

15- Filed JUN 28 1921 ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

by Death (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) H. C. Chesley M. D.
(Coroner)

6-28-21 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemy DATE OF BURIAL, June 29, 1921

20-UNDERTAKER Henry Storck Son ADDRESS 1301 E Eager St.

N. B.—Every item of information should be carefully supplied. AGE should be correctly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(See affadavit over) ✓

D 54928

HEALTH DEPARTMENT—CITY OF BALTIMORE

40

D 54928

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 716 S. Port (St.:) 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Muck

(a) RESIDENCE. NO. 716 S. Port St., Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Muck

6 DATE OF BIRTH (month, day, and year) Jan. 1-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	26	

8 OCCUPATION OF DECEASED Wood Caulker

(a) Trade, profession or particular kind of work ~~Stevedore~~ 074

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Katherine Muck. Wife

(Address) 716 S. Port St.

15 JUN 28 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1921, to June 27, 1921, that I last saw h im alive on June 27, 1921, and that death occurred, on the date stated above, at 2:20 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the esophagus.

about (duration) one yrs. + mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) Edward Dworak, M. D.

. 19 (Address) 821 N. Patt. Pl. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	June 30 1921
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

STATE OF MARYLAND, CITY OF BALTIMORE, to wit:

I hereby certify, that onn this 6th, day of July before me, the subscriber, a Notary Public of said State in and for the City of Baltimore aforsaid, personally appeared Michael Sadowski, the undertaker, and made oath in due form of law that the deceased John Muck, whose occupation he has given as Stevedore on the certificate of the Health Department was given wrong, as the correct occupation of the said deceased John Muck is or was as wood caulker.

&&&& Casimir R Sadowski

Notary Public.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54929

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54929

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 Penna. Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Bridel

(a) RESIDENCE. No. 1824 Penna Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26. 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1 —	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm L Bridel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Idola Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Augusta Ga.

14 Informant (Address) Mrs. Idola Mills 1824 Penna Ave

15 Filed ... 19 ... Robert F. Harrison, Registrar

Burial Permit Clerk.

N 28 7921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from June 26 1921, to June 27. 1921.

that I last saw her alive on June 27 1921

and that death occurred, on the date stated above, at 8:50 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Seven months uterine Gestation) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Past History of Case

(Signed) James Brown M. D.

6/27 1921 (Address) 1837 Pa. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	June 28 1921

20 UNDERTAKER James Easton ADDRESS 916 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54930 ✓ D 54930

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 541 Getting ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Gibbs

(a) RESIDENCE. NO. 541 Getting ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Fountain Gibbs

6 DATE OF BIRTH (month, day, and year): July 9, 1870

7 AGE — Years: 50 — Months: 11 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Martinsburg, W. Va.

PARENTS

10 NAME OF FATHER: Scott W. Vanmeter

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Mary Wolfe.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va.

14 Informant: Fountain Gibbs (Address) 541 Getting

15 Filed Robert P. Harrison, Registrar

JN 28 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 20, 1921, to June 27, 1921, that I last saw her alive on June 26, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Autopsy

(Signed) Wm. T. Seabury, M. D.

6/27 1921 (Address) 638 Fourth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Martinsburg W. Va.

DATE OF BURIAL: June 29 1921

20 UNDERTAKER: E. D. Fanning & Son ADDRESS 1460 Battery Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 54931 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54931

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Hawthorne Road, ST., Roland Park 27 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Roland Park

2-FULL NAME Julia Galuesha Reid

(a) RESIDENCE NO. 118 Hawthorne Road ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
37	37	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Social Worker - Nurse

(b) General nature of Industry, business, or establishment in which employed (or employer) 048

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland Maryland

PARENTS

10 NAME OF FATHER William Galusha Reid

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Virginia

12 MAIDEN NAME OF MOTHER Willie Wallace Banks

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Talbot Jenkins (Address) 118 Hawthorne Road, Roland Park

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

2 8 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. ..., 1920..., to June 27 ..., 1921 ..., that I last saw her alive on June 27 ..., 1921 ..., and that death occurred, on the date stated above, at 11:30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast (left) with operation 3½ yrs. before death, + radium treatment. Metastases

(duration) 4 yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Terminal pneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of January 1918

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Mary A. Hodge, M. D.

, 19 (Address) 943 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL June 29 1921

20 UNDERTAKER J O Mitchell — ADDRESS 1201 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54932 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54932

CERTIFICATE OF DEATH.

104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 569 N. Preston ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Thomas

(Residence in Baltimore: No. 569 N. Preston St.: yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	single

6-DATE OF BIRTH, ~~Dec~~ March 5, 1921
(Month) (Day) (Year)

7-AGE, ~~3~~ yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Infant

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry Thomas

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Eliz. Wright

13-BIRTHPLACE OF MOTHER (State or Country), N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. Thomas

(Address) 569 N. Preston St.

15- Robert P. Harrison,
Filed ....., 191.... Registrar.
JUN 28 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Gastro-enteritis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) ..... ms. Gastro-enteritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Harmony M. D.
(Coroner.)

June 27 1921 (Address) 2502 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS JUN 28

JOHNS HOPKINS HOSPITAL
COMMISSIONER HEALTH

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is necessary important. See instructions on back of certificate.

D 54933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54933

CERTIFICATE OF DEATH.

REGISTERED NO. C 179

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 231 E. Biddle St.; WARD) 11

2-FULL NAME Samuel E. Swann

(Residence in Baltimore: No. 231 E Biddle St. St.: 35 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Colored	Married

6-DATE OF BIRTH, September (Month) ..., 1885 (Day) (Year)

7-AGE,	If LESS than 1 day,
46 yrs. mos. ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)..... 10 11

9-BIRTHPLACE, (State or Country), Maryland

PARENTS:
10-NAME OF FATHER, Benj. Swann
11-BIRTHPLACE OF FATHER (State or Country), Unknown
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Robinson

(Address) 231 E. Biddle St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

JUN 28 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Hypostasis

Immediate

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration) .....yrs.....mos.....ds.

(Signed) J. C. Hennessy M. D. (Coroner.)

June 27 1921 (Address) 2802 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	June 29th 1921
20-UNDERTAKER Chas G Bailey	ADDRESS 1427 Jefferson St

N. B.—Every item of information should be carefully supplied. Accurate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

D 54934 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54934

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 401 S. Payson St. 20 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad Reich

(Residence in Baltimore: No. 401 S Payson St.; yrs., 61 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Single

6-DATE OF BIRTH, ... Jan (Month) 29 (Day), 1860 (Year)

7-AGE, 61 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired Barber
(b) General nature of industry, business, or establishment in which employed (or employer) 004

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John Reich

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dora Durell

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Reich

(Address) 401 S. Payson St

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

N 28 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Rupture of Coronary Artery (Duration) ..... yrs. Sudden mos. ..... ds.

(Signed) James M Fenton M. D. (Coroner.)

June 28, 1921 (Address) 704 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, June 29 1921

20-UNDERTAKER George J Smith

ADDRESS 1005 E Fayette St

A.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54935

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54935

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 244 W. Lanvale ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Bayley Hinder

(a) RESIDENCE. NO. 244 W. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine S. Hinder

6 DATE OF BIRTH (month, day, and year) June 25 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist 055

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Richard B. Hinder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. C. Hinder
(Address) 244 W. Lanvale St

15 Filed Robert P. Harrison, Registrar
N 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1921

17 I HEREBY CERTIFY, That I attended deceased from 1910, 19, to June 28 21, 1921, that I last saw h alive on June 25, 1921, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. D. Lightner, M. D.

, 19 (Address) 211 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 30 1921
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W North Ave.

mation should be carefully supplied. AGE should be stated in YEARS. Exact statement of
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54936

CERTIFICATE OF DEATH.

154

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3603 Maple Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Daniel L. Baker.

(a) RESIDENCE. No. 4030 Falls Road ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lydia A. Baker

6 DATE OF BIRTH (month, day, and year) Feb. 11- 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Medical Doctor

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm F Ray. (Address) 4030 Falls Road.

15 Filed JUN 28 1921 Robert P. Harrison, Registrar

Burial Permit Cleared

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17 I HEREBY CERTIFY, That I attended deceased from May 24 1921, to June 26 1921, that I last saw h[illegible] alive on June 26 1921, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilation
Stiff blood pressure

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) General senility & enlarged prostate G.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. F. Ray, M. D.

6-28-1921 (Address) 1127 Union Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
East Berlin Adams Co. Pa.	6-29 1921

20 UNDERTAKER Greenwalt Son. ADDRESS 617 Cleveland Ave.

N2 8 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. ABBREVIATIONS should be carefully avoided. Exact statement of

Spec.—6-9-19—H. P. Co.—1000 Bks.

149072
D 54937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 54937

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: Ho Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Amby

(a) RESIDENCE. No. 1158 N. Carey St Balty Lift. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alberta Amby. (Wife)

6 DATE OF BIRTH (month, day, and year) Oct 20 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Amby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Weyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va. Md.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUN 29 1921 16 Burial Permit Issued Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1921, to June 27, 1921, that I last saw him alive on June 27, 1921, and that death occurred, on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Since Dec 1920 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

Cirrhosis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unable to say.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical examination + Autopsy.

(Signed) O. R. Mason M. D.

6-28-21, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	June 29 1921
20 UNDERTAKER	ADDRESS
Joseph A Farrell	2319 Division St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54938 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54938

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. #3301 Gwynn Oak Av. ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Hunt Thomas.

(a) RESIDENCE. No. #3301 Gwynn Oak Av. ST., 28 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? 58 yrs. 11 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James L. Thomas

6 DATE OF BIRTH (month, day, and year) July-9-1862.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jas. A. Clark:

11 BIRTHPLACE OF FATHER (city or town) ??????? (State or country) Vermont.

12 MAIDEN NAME OF MOTHER Elizabeth Dickey

13 BIRTHPLACE OF MOTHER (city or town) New York (State or country) New York

14 Informant James L. Thomas (husband)
(Address) 3301 Gwynn Oak Ave.

15 JUN 29 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby. 1 , 1921 , to June 27 , 1921 ,
that I last saw her alive on June 27 , 1921 ,
and that death occurred, on the date stated above, at 2:20 P. m.
The CAUSE OF DEATH* was as follows:

Interstitial nephritis, chronic

about (duration) 3 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? in Balto. city

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? urinary analysis and symptoms.

(Signed) J. T. Kemmell , M. D.

, 19 (Address) 2226 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: June-29-21

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 54939

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #5911 Bellona Ave. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Foreman.

(a) RESIDENCE NO. #5911 Bellona Ave. ST., 27 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 4 mos. 0 ds. How long in U. S., if of foreign birth? 49 yrs. 4 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (None)

6 DATE OF BIRTH (month, day, and year) Feby-28-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer None.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Leander Foreman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Isabella Ingram

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland.

14 Informant Mrs. Isabella I. Foreman (mother)
(Address) 5911 Bellona Av. Govans, City

15 Filed JUN 29 1921 ROBERT J. BRUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1920, to June 28, 1921, that I last saw her alive on June 28, 1921, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute gastro enteritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene H. Falk, M. D.

6/22, 1921 (Address) 2435 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: DRUID RIDGE CEMETERY — DATE OF BURIAL: June-30-21

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

BEFORE SIGNING BE CERTAIN ALL ITEMS are correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spmc.—6-9-19—B. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54940

CERTIFICATE OF DEATH.

151 D 54940

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 329 E 24th St. 12 WARD)

2-FULL NAME Antoni' Dellarocca

(a) RESIDENCE. No. 329 E 24th St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

3 4 2 (6 Mo Pay)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Frank Dellarocca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Victoria Grune

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Frank Dellarocca 329 E 24th St.

15 JAN 29 1921 Registrar

ROBERT E LEWIS

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/21/21, 19.., to 6/21/21, 19..

that I last saw h— alive on 6/21/21, 19..

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard Lang, M. D.

6/24, 1921 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: June 23 1921

20 UNDERTAKER: J Kenny & Co — ADDRESS: 2008 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--6-9-19--H. P. Co.--1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54941

CERTIFICATE OF DEATH.

151 D 54941

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 E 24th ST.: 17 WARD)

2-FULL NAME Joseph Della Rocca

(a) RESIDENCE. (No. 329 E 24th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 28

7 AGE	Years	Months	Days	If LESS than 1 day 3 hrs. or min.
		(1 mo. 3 days)		

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butte Mont.

PARENTS

10 NAME OF FATHER Frank Dellarocca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Victoria Grue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Frank Dellarocca 329 E 24th

15 Filed JUN 29 1921 ROBERT I. [illegible] Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28/21 19

17 I HEREBY CERTIFY, That I attended deceased from 6/28/21, 19 . to 6/28/21, 19 .

that I last saw h— alive on 6/28/21, 19 .

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Malig.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. W. Bernard J. Sevy, M. D.

6/29, 19 21 (Address) 910 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL June 29 1921

20 UNDERTAKER J. Kenny & Co ADDRESS 2008 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54942

CERTIFICATE OF DEATH.

79 D 54942

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5311 St George Ave Govans St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily E. Duncan

(Residence in Baltimore: No. 5311 N Yonge Ave St.: 57 yrs.. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	white	widow

6-DATE OF BIRTH, Sept 14, 1845.
(Month) (Day) (Year)

7-AGE, 76 yrs. 9 mos. 14 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). New York city

PARENTS.

10-NAME OF FATHER, Joseph J. Herron

11-BIRTHPLACE OF FATHER (State or Country). N. York.

12-MAIDEN NAME OF MOTHER Virginia Harrell

13-BIRTHPLACE OF MOTHER (State or Country). Conn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Willie D. Lynn

(Address) 5311 St George Ave Govans

15- JUN 29 1921 [illegible] I [illegible]

Filed....., 191.... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 28 1921, to June 28 1921, that I saw her alive on June 28 1921, and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion accompanied by sudden heart collapse

(Duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) E. H. Duncan M. D.

June 30, 1921. (Address) Govanstown Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rest h. Cem. Govans — DATE OF BURIAL, June 29.., 1921..

20-UNDERTAKER J. Chas Burns Sons — ADDRESS Towson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54943

D 54943

CERTIFICATE OF DEATH.

138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary A. Butler.

(a) RESIDENCE. NO. 2216 E. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Chas. H. Butler

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 33 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Janesek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Chas H. Butler

(Address): 957 N. Collington Ave

15 Filed JUN 29 1921 ROBERT F. BRAUER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1921, to June 27, 1921; that I last saw her alive on June 27, 1921, and that death occurred, on the date stated above, at 11 50 P m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): Nephritis Eclampsia

(duration) yrs. mos. 10 hrs. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Manifestations

(Signed) R. W. Richardson, M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: June 30 '21

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of (illegible) TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54944

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST.: 44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Louise Young

(a) RESIDENCE. NO. 1820 Linden Ave. ST., 14 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 76 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (None)

6 DATE OF BIRTH (month, day, and year) About-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 76 years.		?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (None) 500

(b) General nature of industry, business, or establishment in which employed (or employer) (None)

(c) Name of employer (None)

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Young

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Emily Richardson

13 BIRTHPLACE OF MOTHER (city or town) York
(State or country) Penna.

14 Informant Mrs. Ella H. Raine (sister)
(Address) 1820-Linden Av. City.

15 Filed JUN 29 1921 [illegible] Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1921

17 I HEREBY CERTIFY, that I attended deceased from June 8 1921, to June 28 1921.

that I last saw h[illegible] alive on June 28 1921.

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis -

(duration) ? yrs. mos. ds.

CONTRIBUTORY Myocarditis -
Cachexia (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home (Baltimore)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Wm B Mayo - M. D.

, 19 (Address) Catonsville Apt. - Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
BALTIMORE CEMETERY	June-30-27

20 UNDERTAKER	ADDRESS
STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54945

CERTIFICATE OF DEATH.

120 D 54945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 Hanover ST.: 23 WARD)

2-FULL NAME Helen L. Douglass

(a) RESIDENCE. No. 2125 Hanover ST., 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ed. F. Douglass

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Govt Md.

PARENTS

10 NAME OF FATHER John B Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ed. F. Douglass

(Address) 2125 Hanover St.

15 Filed JUN 29 1921, 19 [illegible] Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to June 27, 1921, that I last saw h[illegible] alive on June 27, 1921, and that death occurred, on the date stated above, at 2:15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. R. Campbell M. D.

June 28, 1921 (Address) 1684 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	6/29 1921
20 UNDERTAKER	ADDRESS
J. E. Oakley & Son	818 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54946

CERTIFICATE OF DEATH.

1524 54946

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 N. Broadway ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Seidt

(a) RESIDENCE. NO. 127 N. Broadway ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Catherine Seidt

6 DATE OF BIRTH (month, day, and year) Oct 7 - 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 900

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Seidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Seidt
(Address) 127 N Broadway

15 Filed JUN 29 1921 ROBERT I KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1921

17 I HEREBY CERTIFY, That I attended deceased from February 19 . to June 28 . 1921 .
that I last saw him alive on June 24 . 1921 .
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank F Lloyd . M. D.

, 19 (Address) 1500 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 30 1921
20 UNDERTAKER	ADDRESS
A. Sander & Sons	1710 Pratt St

Italics should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—11. P. Co.—1000 Bks.

D 54947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 54947

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S. Broadway ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Lederer

(a) RESIDENCE. No. 105 S. Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Lederer

6 DATE OF BIRTH (month, day, and year) June 25, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Lee Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Eliza M. Northey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant George Lederer

(Address) 105 S. Broadway

15 Filed JUN 29 1921 ROBERT I. KRAUTER Registrar

Burial Permit Oleat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17

I HEREBY CERTIFY, That I attended deceased from June 24 1921, to June 26, 1921, that I last saw h[illegible] alive on June 26, 1921, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Hem. c.v. Heat Exhaustion

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Failure —

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Mark E. Brosler, M. D.

June 27 1921 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL June 29 1921

20 UNDERTAKER H. Sander & Sons

ADDRESS 1710 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54948

CERTIFICATE OF DEATH.

179 D 54948

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 S. Chester ST.: 2 WARD)

2-FULL NAME Samuel F. Maxwell

(a) RESIDENCE. NO. 214 S. Chester ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma S. Maxwell

6 DATE OF BIRTH (month, day, and year) April 18, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant & Coal Retired 5 years

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel Maxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) P. a.

12 MAIDEN NAME OF MOTHER Elizabeth Seward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Miss Fanny Maxwell 214 S. Chester St.

Filed JUN 29 1921 MONDAY F. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1921

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1921, to June 26, 1921, that I last saw h— alive on June 26, 1921, and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Heat - a.s. Heat Prostration

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. A. Bruehl, M. D.

(Address) 1250 Eutaw

June 27/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	June 29 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Pleasant St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54949

CERTIFICATE OF DEATH. X 61 D 54949

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Union Memorial Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Willie Hoke.

(a) RESIDENCE. NO. Fort Mill South Carolina ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug 11 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	10	17	

8 OCCUPATION OF DECEASED 068

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER W. B. Hoke

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mary Spratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant (Address) Jas. McKee Hoke Fort Mill S.C.

15 Filed JUN 29 1921 ROBERT J. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to June 28, 1921, that I last saw h in alive on June 28, 1921, and that death occurred, on the date stated above, at 5:30 p m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goiter

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of June 28, 1921

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. H. Janssenberger, M. D.

6/28 1921 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fort Mill S. C	June 29 1921
20 UNDERTAKER	ADDRESS
J O Mitchell	120 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54950

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54950 ✓

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Whiting.

(a) RESIDENCE. NO. 1406 Webb ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of (~~or WIFE of~~) Jennie Whiting

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	–	–	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Z. F. Whiting.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Records (Address) City Hospital, Bay View

15 FILED JUN 29 1921 ROBERT I. KRAMER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1921, to June 26, 1921, that I last saw him alive on June 26, 1921, and that death occurred, on the date stated above, at 3 45 A.m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No especial test.

(Signed) B. Herman, M. D.

6-26 1921 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 29 1921

20 UNDERTAKER ADDRESS

R. B. Frost 1405 McElderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 54951
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310 Hunter St ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Blackwell

(a) RESIDENCE. No. 2310 Hunter St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col aa	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 170

(b) General nature of Industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Blackwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) in Maryland

14 Informant Mary Lane
(Address) 2310 Hunter St

15 JUN 29 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1921, to June 27, 1921,
that I last saw h[illegible] alive on June 27, 1921,
and that death occurred, on the date stated above, at 3.55 p m.

The CAUSE OF DEATH* was as follows:

Acute Malignant Endocarditis

(duration) yrs. ? mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Rheumatic Fever (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Edd Hall, M. D.

. 19 (Address) 426 E 23 dd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	June 30 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54952

CERTIFICATE OF DEATH.

120

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Hotel Belvedere ST. 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Wm J. St. Leger

(Residence in Baltimore: No. 1209 Vall. (St., ave., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widower

6-DATE OF BIRTH. ....., 1 .....
(Month) (Day) (Year)

7-AGE. 37 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): D of C

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. B. St Leger

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Mary Tobey

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jam. St Leger

(Address) 1209 Valley

15- ROBERT J. KRAUTER

JUN 29 1921 191..... Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebro Hepatitis

Acute Pneumonia (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Cirrh Cardiac dilatation

Syphilis (Duration) ..... yrs. ..... mos. ..... da.

(Signed) ..... M. D.
(Coroner)

Jan 28, 191... (Address) 1039 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State 4 yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral DATE OF BURIAL, July 1, 1921

20-UNDERTAKER H. C. Wiedefeld ADDRESS 914 Greenmount Av

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54953

40

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 East Madison ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Leonard

(a) RESIDENCE. NO. 918 East Madison ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Leonard

6 DATE OF BIRTH (month, day, and year) May 4 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	24	

8 OCCUPATION OF DECEASED 015

(a) Trade, profession or particular kind of work Retired (Carpenter and Staircase builder

(b) General nature of industry, business, or establishment in which employed (or employer) for U.S. Government Light House Service

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

11 Informant Mrs. Margaret Leonard

(Address) 918 East Madison St

15 Filed JUN 29 1921 19 ... Register's No. 01861

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 28th 21

17 I HEREBY CERTIFY, That I attended deceased from March 15 1921, to June 28 1921, that I last saw h in alive on June 24 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver
arterio sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) W. D. Tebbett M. D.

June 29 1921 (Address) 2990 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL June 30 1921

20 UNDERTAKER Jos. B. Cook — ADDRESS 1003 N. Bolton St

be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54954

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54954 ✓

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N. Port St. ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea B. Schleupner

(a) RESIDENCE. No. 124 N. Port St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George A. Schleupner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Amelia F. Shaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant George A. Schleupner

(Address) 124 N. Port St

15 Filed JUN 29 1921, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-26, 1921, to 6-28, 1921, that I last saw h[illegible] alive on 6-28, 1921, and that death occurred, on the date stated above, at 10.15 A. m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia over

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J Rennert, M. D.

, 19 (Address) 152 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL June 30 1921

20 UNDERTAKER Lilly and Zeih.

ADDRESS 403 S. Mo[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54955 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 54955

CERTIFICATE OF DEATH. 48

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7332 E. Baltimore ST.; 6 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Kiehne

(a) RESIDENCE. No. 7332 E. Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Kiehne

6 DATE OF BIRTH (month, day, and year) Jan. 15-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary MacNeal.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Stephen G. Nelson 7332 E. Baltimore St.

15 JUN 29 1921 Robert . Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from July— 1920. to June 27. 1921.

that I last saw h or alive on June 26. 1921.

and that death occurred, on the date stated above, at 12.10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 mos. ds.

CONTRIBUTORY (Secondary) Heart Disease

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual symptoms

(Signed) Wm. A. Brumm, M. D.

(Address) 1238 Bolton 19/4 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	June 30 1921

20 UNDERTAKER Lilly and Zeller ADDRESS 403 S. Wolfe St.

THIS IS A PERMANENT RECORD. ENTRY [illegible] should be stated EXACTLY. PHYSICIANS should mation should be carefully supplied. AGE it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54956

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 N. Chester ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria K. Dreyler

(a) RESIDENCE. NO. 735 N. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) July 9 - 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Dreyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna M. Middlington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Charles Dreyler
(Address) 735 N. Chester St.

15 Filed JUN 29 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1— 1921 to June 27 1921.
that I last saw h alive on June 26 1921.
and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Autum. Phy. Ex.

(Signed) F. C. Bradley, M. D.

19 (Address) 1248 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	June 30 1921
20 UNDERTAKER Lilly & Ziehn	ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54957

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54957

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2845 Bernard St.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gorrell

(a) RESIDENCE. NO. 2845 Bernard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER Charles H Gorrell

11 BIRTHPLACE OF FATHER (city or town) Madison co
(State or country) va

12 MAIDEN NAME OF MOTHER Lena Smith

13 BIRTHPLACE OF MOTHER (city or town) Culpepper co
(State or country) va

14 Informant Mrs Gorrell
(Address) 2631 N Calvert st

15 Filed JUN 29 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1921, to June 29, 1921, that I last saw her alive on June 28, 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

congenital debilitas

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) premature (8 months)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical

(Signed) Mrs Gorrell, M. D.

, 19 (Address) 2631 N Calvert st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Mary's Hampden	6/30 1921
20 UNDERTAKER Harwood Hixson	ADDRESS 647 Cathedral

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54958

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hildebrandt

(a) RESIDENCE. No. Unknown St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, New City Hospital.

15 Filed 6/28/1921 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1921

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1921 to June 28, 1921, that I last saw h[er] alive on June 27, 1921, and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Arteio-sclerosis. (No cerebral hemorrhage)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test

(Signed) Hetherman, M. D.

6/28/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — DATE OF BURIAL: 6/30 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E Nath

JUN 29 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54959

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and ~~number~~.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1162 E Monument ST.; ..... WARD)

2-FULL NAME Margaret W McGuire

(a) RESIDENCE. No 1162 E Monument ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 50 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) .....

7 AGE: Years 69; Months .....; Days .....; If LESS than 1 day, hrs. ..... or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 800

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Edmd Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary E McGuire (Address) 1162 E Monument

15 Filed JUN 29 1921, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to June 29, 1921, that I last saw h[er] alive on June 29, 1921, and that death occurred, on the date stated above, at 12.40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
Mitral Regurgitation

(duration) yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Walter J. Murray, M. D.

6-29 1921 (Address) 5 No. Bremerton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: July 1 19..

20 UNDERTAKER: Robt J Johnson & Son

ADDRESS .....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54960

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3104 Cedar Ave. ST.: 13 (WARD)

2-FULL NAME Mary Henry

(a) RESIDENCE No. 3104 Cedar Ave. ST. 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Aaron Henry

6 DATE OF BIRTH (month, day, and year): April 7 1848

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
73	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mt. Washington Maryland

PARENTS

10 NAME OF FATHER: Samuel Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wm. Henry
(Address) 3319 Chestnut Ave

15 Filed Robert P. Harrison, Registrar
JUN 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1921, to June 27, 1921, that I last saw her alive on June 26, 1921, and that death occurred, on the date stated above, at 1.15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Cardiac Compression

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible] M. D.

. 19 (Address) June 28-21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: June 30 1921

20 UNDERTAKER: Horace F. Burged — ADDRESS: 363 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54961 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54961

CERTIFICATE OF DEATH.

X 175-002

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. St agnes Hospital St. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ada Pfeiffer

(Residence in Baltimore: No. Relay Md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): single

6-DATE OF BIRTH: Dec (Month) 25 (Day), 1923 (Year).

7-AGE: 27 yrs. 6 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Balto city.

PARENTS.

10-NAME OF FATHER: Azariah Downs

11-BIRTHPLACE OF FATHER (State or Country): maryland

12-MAIDEN NAME OF MOTHER: Ida jones

13-BIRTHPLACE OF MOTHER (State or Country): maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Phelps

(Address) Relay md

15- Robert P. Harrison,

Filed ....., 191.....

JUN 29 1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 29 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull
Motor Cycle Accident
.....
..... (Duration) .....yrs. mos. 2 hrs

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) James M Fenton M. D. (Coroner.)

June 29, 1921 (Address) 701 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. 1 ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? Washington Rd & Mt Winans

Former or usual residence Relay Md

19-PLACE OF BURIAL OR REMOVAL, Druid Hill Cem. DATE OF BURIAL, June 30, 1921

20-UNDERTAKER W J Gardner ADDRESS 1201 North Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

147733 D 54962

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

61-001D 54962

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Mitchell

(a) RESIDENCE. NO. 612 S Lakewood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2yr mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5- 21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
		3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child.

(b) General nature of industry, business, or establishment in which employed (or employer) 600

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm Mitchell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Sauer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) U.S.

14 Informant (Address) Johns Hopkins Hospital, Record

15 Filed Robert F. Harrison, Registrar
Burial Permit Clerk.

N 291921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1921, to June 29, 1921,

that I last saw h~~e~~ alive on June 29, 1921,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Meningitis, Menin[illegible]

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6/19/21

Was there an autopsy? Yes

What test confirmed diagnosis? Cultures, Smears, Autopsy

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	June 30th 1921
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	906 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Co.—1000 Bks.

D 54963

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 54963

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Fleet, ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph. Walter

(a) RESIDENCE. No. 2282 Fleet. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 0 mos. 0 ds. How long in U. S., If of foreign birth? 30 yrs. 0 mos. 0 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) March 19-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of Industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Joseph. Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Magdalena Shreider.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Magdaleda Walter.
(Address) 2282 Fleet St

15 Filed ....., 19.....
Robert P. Harrison, Registrar

JN 29 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1921, to —, 19—, that I last saw him alive on June 27, 19 21, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.
Tuberculosis

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Haemorrhage

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Not D Dy Knowledge

What test confirmed diagnosis? Clinical Signs

(Signed) H D Wheaton, M. D.

, 19 (Address) 4235 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 30 1921
20 UNDERTAKER	ADDRESS
Wm Fialkowski	1618 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54964

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54964

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 751 Vine St. ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Worley

(a) RESIDENCE. NO. 751 Vine St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	widow

5a If married, widowed, or divorced (or) WIFE of Charles Worley

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) Laundress 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER Stephen Carpter

11 BIRTHPLACE OF FATHER (city or town) Cambridge (State or country) Md

12 MAIDEN NAME OF MOTHER Julia ——

13 BIRTHPLACE OF MOTHER (city or town) Cambridge (State or country) Md

14 Informant Susie Carpter (Address) 25 E. East St.

15 Filed JUN 30 1921 ROBERT J. CRAIG Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to June 28, 1921, that I last saw h— alive on June 21, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pleurisy 0042

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 1921

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. D. Smith, M. D.

, 19 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 30 21
20 UNDERTAKER	ADDRESS 916 Pa Ave
David Earhart	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tubercular

D 54965

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54965

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 642 Jasper St. 17 WARD)

REGISTERED NO. C 1792

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Smith

(Residence in Baltimore: No. 642 Jasper St.: 35 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, November, 1877
(Month) (Day) (Year)

7-AGE, 44 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (General) 040

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John H. Smith

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mahoney

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Henry Smith

(Address) 642 Jasper St.

15- JUN 30 1921 DEPUTY REGISTRAR

Filed ..... 191.....

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Prostration

about 3 minutes (Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. J. Hennessy M. D.
(Coroner.)

June 29, 1921 (Address) 2502 Effingham Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, June 30 1921

20-UNDERTAKER Emil Egerton ADDRESS 916 Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 54966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 54966

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 740 Warsche St. W. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Mekinsfel-

(Residence in Baltimore: No. 740 Warsche st- St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colrd	Sngle

6-DATE OF BIRTH. ..... Nov. ....., 1920
(Month) (Day) (Year)

7-AGE. ..... yrs. 7 mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Home
(b) General nature of industry, business, or establishment in which employed (or employer). 006

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John H Mekinsfel,

11-BIRTHPLACE OF FATHER (State or Country). Virginia ~~Baltimore~~

12-MAIDEN NAME OF MOTHER Grace Gregory

13-BIRTHPLACE OF MOTHER (State or Country). Pa-

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Luna ave

15-

ROBERT J KRAUTER

Filed JUN 30 1921 191. (Burial) Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. ..... June ..... 29 ..... , 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Coroner, or ~~autopsy or inquiry.~~) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) ..... yrs. ..... mos. 3 ..... ds.

(Signed) W R Jones M. D.
(Coroner.)

6-29, 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Penn

DATE OF BURIAL. June 30, 1921

20-UNDERTAKER Daniel Easton

ADDRESS 916 Luna ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54967

CERTIFICATE OF DEATH.

D 54967

1-PLACE OF DEATH University Hospital

REGISTERED NO. 15-126

CITY OF BALTIMORE: (No. ____ St.: 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Hess

(a) RESIDENCE. No. 3612 Reisterstown Road St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dina Hess

6 DATE OF BIRTH (month, day, and year): Sept 28/1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Stores

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Lippman Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): L Hess 3612 Reisterstown Rd

15 Filed JUN 30 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13 . 1921 . to June 28 . 1921 . that I last saw h m alive on June 28 . 1921 . and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of June 22, 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ahel Shalom	June 30th 1921

20 UNDERTAKER: David Sondheim ADDRESS 1184 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Jones

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54968

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 54968

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jones.

(a) RESIDENCE. No. 1144 Caroline Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	B.	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Divorce

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None work.

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Parker Elvin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John Jones (Address) 1811 Orleans st

15 Filed JUN 30 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28 19 21

17 I HEREBY CERTIFY, That I attended deceased from ..... 19.. to 6/28 19 21.

that I last saw h[illegible] alive on 6/28 19 21.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Tumor of Uterus with Generalized Carcinosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degen — 14

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of —

Was there an autopsy? Yes —

What test confirmed diagnosis? Microscopic Examination

(Signed) [illegible] M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	June 30 19 21

20 UNDERTAKER John W Henderson ADDRESS 1002 E Monument st

Instructions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1090 Bks.

D 54969 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D 54969

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bay View Hospital REGISTERED NO.

CITY OF BALTIMORE, NO. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Jones

(a) RESIDENCE. NO. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Bay View Hospital (Address)

15 Filed JUN 30 1921 ADOLPH L. KRAUSE Registrar Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1919, to June 28, 1921, that I last saw h alive on June 27, 1921, and that death occurred, on the date stated above, at 9:00 a.m.

THE CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) H. Fred Smith, M. D.

6/29/21 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Osbury Cemetery	June 30 1921

20 UNDERTAKER ADDRESS

Wilson, Davis, 315 N. Edmondson

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54970

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1245 James ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E. Deems.

(a) RESIDENCE. NO. 1245 James ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Deems

6 DATE OF BIRTH (month, day, and year) May 20/1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward E Deems

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jane C Grady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Ella Deems 1245 James St

15 Filed JUN 30 1921 ROBERT J. [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from May. 26. 1921. to June. 29. 1921. that I last saw him alive on June. 29. 1921. and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart.

(duration) yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Herbert C. Blake, M. D.

, 19 (Address) 1014 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Londa Park	July 2 1921
20 UNDERTAKER	ADDRESS
W. M. Cook	502 E Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54971

CERTIFICATE OF DEATH.

D 54971

22 169

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. Clifford's Pond, Westport St.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard S. McCauley.

(Residence in Baltimore: No. 224 S. Eutaw St. St.: yrs., mos. ds.)

18 ---------

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, January 27th. 1900, 1
(Month) (Day) (Year)

7-AGE, 21 yrs. 5 mos. 0 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chaffeur.
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Annapolis, Md

PARENTS.

10-NAME OF FATHER, George McCauley.

11-BIRTHPLACE OF FATHER (State or Country), A. A. Co. Md.

12-MAIDEN NAME OF MOTHER, Carrie Parker.

13-BIRTHPLACE OF MOTHER (State or Country), Annapolis, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George McCauley, (father)

(Address) 1222 Willian St.

15- Filed JUN 30 1921 ROBERT I. KRAUTH Clerk
Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally drowned while in bathing.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto H. Leimandt M. D.
(Coroner.)

June 28 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, June 30 1921

20-UNDERTAKER William Cook

ADDRESS 307 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54972

CERTIFICATE OF DEATH.

79 ~ D 54972

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2938 Huntingdon Ave 17 WARD)

2-FULL NAME Kate E. Jones

(a) RESIDENCE. NO. 2938 Huntingdon ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
fem	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Phemion Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs K. Naylor
(Address) 2938 Huntingdon Ave

15 Filed ..... 19 ..... ROBERT I. KRAUTH Registrar
JUN 30 1921 Social Service Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16 1921, to June 29, 1921, that I last saw her alive on June 29, 1921, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease.

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo W H Offutt, M. D.

1924 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 1 1921

20 UNDERTAKER A. L. Marshall ADDRESS 3539 Fall Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Williams

D 54973

D 54973 — 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Florence Williams

(a) RESIDENCE. NO. 3234 Kingsley ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Record

15 Filed JUN 30 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/5, 1921, to 6/29/21, 1921, that I last saw him alive on 6/29/21, 1921, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Emphysema (duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Ralph, M. D.

6/29, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hollansport Va	6/30/21

20 UNDERTAKER Geo. R. Farley ADDRESS Fulton Fayette

This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54974

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54974

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 N. Patterson Park Ave St.; 6 WARD)

REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johannah Pullmann

(Residence in Baltimore: No. 219 N Patterson Park Ave St.; 50 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 7, 1849 (Month) (Day) (Year)

7-AGE, 71 yrs. 6 mos. 23 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Franz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Franz

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Seaver

(Address) 238 S Patterson Pk

15-

Filed JUN 30 1921, 191. [redacted]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1921, to June 27 1921, that I saw her alive on June 27 1921, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Mitral insufficiency)

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Henry B Kelly M. D.

June 30, 1921 (Address) 2504 O'Hara St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem — DATE OF BURIAL, July 1..., 1921

20-UNDERTAKER Peter Nicolaus — ADDRESS 2046 Easter

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Ida Jones

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54975

CERTIFICATE OF DEATH

37 D 54975

REGISTERED NO.....

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Jones

(a) RESIDENCE. NO. 1003 N. Chapel ST., ... WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 2 mos. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Black | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: Years 39. | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER: Edward Jones
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Bay View Hospital Balto. Md.

15- FILED JUN 30 1921 ROBERT I. FEUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to June 27, 1921, that I last saw h[illegible] alive on June 26, 1921, and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (3 the (Antone).

CONTRIBUTORY (Secondary) Lueta Clofeatur (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serologic

(Signed) H. Goldsmith M. D.

6/27/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Williams Port-St And — DATE OF BURIAL: June 30 1921

20 UNDERTAKER: Mrs R A Elliott — ADDRESS 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54976

CERTIFICATE OF DEATH.

55-001 D 54976

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. (OR WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Leslie Kuppuman

(a) RESIDENCE. No. 237 E. 3rd St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 21-20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	~~2~~	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER William Kuppuman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark ~~Md~~

12 MAIDEN NAME OF MOTHER Carrie Setterfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Willy Kuppuman

(Address) 237 E. 3rd

Filed . 19 Registrar

JUN 30 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1921

17 I HEREBY CERTIFY, that I attended deceased from June 7- , 1921, to June 28, 1921.

that I last saw her alive on June 28, 1921.

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis lethargica

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) Dudley P. Bowe M. D.

. 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL July 1 1924

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Aisquith

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 37 D 54977

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 W. Montgomery ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Pryor

(a) RESIDENCE. NO. 109 W. Montgomery ST.. WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct — 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Express Wagon

(b) General nature of industry, business, or establishment in which employed (or employer): Himself.

(c) Name of employer: Spotsylvania Co.

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: William Pryor (King George Co.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Maria Pryor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Spotsylvania Co. Virginia

14 Informant: Edward Pryor (Address): Washington D.C.

15 JUN 30 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 28, 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 5, 1921, to June, 28, 1921, that I last saw h[illegible] alive on June, 26, 1921, and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Syphilis

(duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical -

(Signed) Dan Franklin M. D.

6/29/1921 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct.	July 1st 1921
20 UNDERTAKER	ADDRESS
J. L. Brownfield Son	108 W. Mont

[illegible] & KRUTER
Registrar
Bureau of Vital Statistics

MAKE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54978

CERTIFICATE OF DEATH.

66 D 54978

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Aged Home ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Rosenstein

(a) RESIDENCE. No. 115 Ausgusta St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of O. L. Rosenstein

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1411 E Balt st

15 Filed JUN 30 1927 BURKE & TRAUTZ Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1927

17 I HEREBY CERTIFY, That I attended deceased from May 25 1927, to June 29 1927, that I last saw h alive on June 29 1927, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Senile Palsy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M J Baylin, M. D.

6/30. 1927 (Address) 716 Augusta st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	6/30 1927
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balt st

be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54979

D 54979

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 109 E. Stockton St.; 19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Willgoine

(a) RESIDENCE. No. 109 E. Stockton St.

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9- 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	-	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer in Coal yard

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Cumberland Coal Co.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John H Willgoine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Maria Dwoaff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Jacob Willgoine 218 E. Lanvale St.

15 Filed JUN 30 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1924

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1924. to June 28, 1924.

that I last saw h- alive on June 27, 1924.

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D.

(Address) 3134 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: June 30th 1924

20 UNDERTAKER: A. Jones ADDRESS: 207 S. Sharp St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Titus

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54980

CERTIFICATE OF DEATH.

104 ✓ D 54980

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 913 n. Calhun ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward M. Titus

(a) RESIDENCE. No. 913 n Calhun ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs 6 mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city

PARENTS

10 NAME OF FATHER James Titus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto city

12 MAIDEN NAME OF MOTHER Elsa Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) James Titus 1913 n Calhun St.

15 Filed JUN 30 1921 Robert I. Rivlin Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1921, to June 26, 1921.

That I last saw h[illegible] alive on June 26, 1921.

and that death occurred, on the date stated above, at 9.25 a m.

The CAUSE-OF DEATH* was as follows:

Acute Ileocolitis

(duration) yrs mos 5 ds.

CONTRIBUTORY (Secondary) Summer heat

(duration) yrs mos 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) J Edward Fisher M. D.

6-29 1921 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Auburys — DATE OF BURIAL June 30 1921

20 UNDERTAKER Sam'l H. Chase & Son — ADDRESS 1405 Mlches

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54981

CERTIFICATE OF DEATH.

X 20 D 54981

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; ....WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elaine Cariec

(Residence in Baltimore: No. Hebrew Hospital St.: yrs., mos. 1 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 4, 1917 (Month) (Day) (Year)

7-AGE, 4 yrs. 1 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country) Edenton N C.

PARENTS.

10-NAME OF FATHER, Walter M Carico

11-BIRTHPLACE OF FATHER (State or Country), N C.

12-MAIDEN NAME OF MOTHER Ethel Gentry

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter M Carico

(Address) Delta Pa.

15- ROBERT J TRAUTZ

Filed JUN 30 1921, 191.....Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 29, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 28 1921, to June 29 1921, that I saw h.r alive on June 29 1921, and that death occurred, on the date stated above, at 11 5 m.

The CAUSE OF DEATH* was as follows:

Sepsis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Erysipelas of Face

(Duration) ....yrs. ....mos. 5 ds.

(Signed) J B Zimbalist M. D.

6/30/1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Delta Pa.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Delta Pa. DATE OF BURIAL, June 30, 1921

20-UNDERTAKER H F Redmond Sons & Co

ADDRESS York Pa

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54982

CERTIFICATE OF DEATH.

104 D 54982

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1876 N. Duncan St. ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Seth McElroy.

(a) RESIDENCE. NO. 1876 N. Duncan ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 12-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter J. McElroy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Pauline Pasterfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Pauline McElroy

(Address) 1876 N. Duncan St.

15 Filed JUN 30 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 24 1921, to June 29. 1921.

that I last saw him alive on June 28 1921.

and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible Symptoms

(Signed) Geo Kelly, M. D.

6-29-21 (Address) 1937 Orleans St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	June 30th 1921
20 UNDERTAKER Lilly & Zile	ADDRESS 403 S. Wolfe

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 54983

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D 54983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 N. Caroline ST., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry D ettenthaler.

(a) RESIDENCE NO. 1123 N. Caroline ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Walburga Dettenthaler

6 DATE OF BIRTH (month, day, and year) June 1-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Dettenthaler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Walburga Dettenthaler
(Address) 1123 N. Caroline St.

15 Filed JUN 30 1921 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1921

17 I HEREBY CERTIFY, That I attended deceased from April - 22 . 1921 , to June - 28 . 1921 ,
that I last saw him alive on June 25 . 1921 ,
and that death occurred, on the date stated above, at 9.22 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation - Aortic Regurgitation
Cystitis - Arteriosclerosis - Dementia.
Hemiplegia.

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) Senility

(duration) ... yrs. 2 mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) William H. Schwartz M. D.

June 29, 1921 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL July 1 1921

20 UNDERTAKER Lilly and Zeile. ADDRESS 423 N. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 54984 — 6-691 — Registered No. D 54984

1 PLACE OF DEATH

City of Baltimore (No. 708 Gouch ave St.: 9 Ward)

2 FULL NAME Sonnie Frink

(Residence in Baltimore: No. 708 Gouch Ave St.: 32 yrs. mos. ds.)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: October 16th (Month) (Day), 1864 (Year)

7 AGE: 57 yrs. 4 mos. 18 ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer): D09

9 BIRTHPLACE (State or country): Buffalo New York

PARENTS

10 NAME OF FATHER: Henry A. Frink

11 BIRTHPLACE OF FATHER (State or country): Massachusetts

12 MAIDEN NAME OF MOTHER: Mabel M. Bardell

13 BIRTHPLACE OF MOTHER (State or country): Massachusetts

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. S. Parkhurst

(Address) 1410 Park Ave

15 FILED JUN 30 1921 ROBERT J KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 28th (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18th, 1921, to June 28th 1921, that I saw her alive on June 26th, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds

Contributory (SECONDARY) Pneumonia was a complication of Diabetes (Duration) ..... yrs. ..... mos. ..... ds.

(Signed), A. S. Parkhurst M. D.

June 28, 1921 (Address) 1410 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: June 30, 1921

20 UNDERTAKER: John C Mitchell — ADDRESS: 120 N Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Reiston

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54985

28 D 54985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 545 Lafayette ave ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Reiston

(Residence in Baltimore: No. 545 Lafayette ave St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 1885 (Month) (Day) (Year)

7-AGE, 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): 074

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Robt. Reiston

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Rachel Reed

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alonzo Reiston

(Address) 545 Lafayette ave

15- ROBERT J. BRUCE Registrar.

Filed JUN 30 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 29th 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 8th 1921, to June 29th 21, that I saw h alive on June 28th 1921, and that death occurred, on the date stated above, at 1:30 pm

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 mos. ds.

(Signed) A. L. Fuss Ellis M. D.

6-29, 1921 (Address) 924 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Auburn

DATE OF BURIAL, 7-1-3, 1921

20-UNDERTAKER Guilfoin Corp'n

ADDRESS 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Murray 3632 Rotand

D 54986

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54986

CERTIFICATE OF DEATH.

169 V

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Stone Run Guilford St. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethan H Cook

(Residence in Baltimore: No. 516 Gittman Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 2 (Day), 1912 (Year)

7-AGE, 9 yrs. mos. ds.

If LESS than 1 day, hrs. or mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, William H Cook

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Daisy V Jones

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H Cook

(Address) 516 Gittman

15- ROBERT J KRAUTER

Filed JUN 30 1921 CITY REGISTRAR Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Newman M. D.
(Coroner.)

June 30, 1921 (Address) 3632 Rotand

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, July 1, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E North

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54987

CERTIFICATE OF DEATH.

64 D 54987

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1147 Carroll ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Mitchell

(a) RESIDENCE. NO. 1147 Carroll ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Albina D. Mitchell.

6 DATE OF BIRTH (month, day, and year) Oct 17-1847.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ice Business

(b) General nature of industry, business, or establishment in which employed (or employer): U H S

(c) Name of employer: W. P. Wagner & Sons.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: David Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Dorothy Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Albina D. Mitchell

(Address) 1147 Carroll

15 Filed JUN 30 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to June 29, 1921, that I last saw him alive on June 28, 1921, and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Morley Hoag, M. D.

June 29 1921 (Address) 729 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | DATE OF BURIAL: July 2 1921

20 UNDERTAKER: Wm Cook | ADDRESS: 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cliff — Insley

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54988 — 75001 E. Balto — D 54988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Johns Hopkins ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Lee Cliff.

(Residence in Baltimore: No. Neil Point Rd St. Bay Shore St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... Jan (Month) 20 (Day), 1901 (Year)

7-AGE. 20 yrs. mos. ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 087

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Thos J. Cliff.

11-BIRTHPLACE OF FATHER (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Maya Skaton

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos J. Cliff

(Address) Bay Shore

15- Filed JUN 30 1921 ROBERT I. BAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Ribs by Auto

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

June 30, 1921 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Bay Shore

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL,
Oakland	July 1, 1921
20-UNDERTAKER	ADDRESS
William Cook	502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Kass.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54989

D 54989

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 616 W Cross ST.: 21 WARD)

2-FULL NAME Margaret Kass

(a) RESIDENCE. NO. 616 W Cross ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wht	Widowed

5a If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of Peter Kass

6 DATE OF BIRTH (month, day, and year) Aug 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Valentine Jockel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie C. Heiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Kellar
(Address) 616 W Cross st

15 Filed JUN 30 1921 SOLOMON S. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 24 1921. to June 29. 1921.
that I last saw h alive on June 28. 1921.
and that death occurred, on the date stated above, at 10:40 a m.
The CAUSE OF DEATH* was as follows:

Nephritis Chronic.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Krantz M. D.

6/29 1921 (Address) 517 Forest St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross. DATE OF BURIAL July 2 1921

20 UNDERTAKER Wm Frost & Co ADDRESS 502 E Hoffman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54990

HEALTH DEPARTMENT—CITY OF BALTIMORE

1603

D 54990

CERTIFICATE OF DEATH.

REGISTERED No. C 168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dicke (Unknown)

(Residence in Baltimore: No. 24 Pratt St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Unknown

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 44 yrs. about mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Unknown

9-BIRTHPLACE, (State or Country). Unknown

PARENTS

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed JUN 30 1921, 191 ROBERT J. BRAUER Registrar. Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, an inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonalis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (Duration) yrs. mos. ds.

(Signed) W. S. Riley M. D.
(Corner)
June 30, 1921 (Address) Health Department

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death 3 days yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY. DATE OF BURIAL. ..... 19..

20-UNDERTAKER Commissioner Health. ADDRESS JUN 29 1921

W. E. WOODALL.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

148995

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54991

CERTIFICATE OF DEATH.

9 ✓

D 54991

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Johns Hopkins Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Hill

(a) RESIDENCE. NO. 3726 Loudon St ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3 - 21.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Herman J Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Ida Bowder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Johns Hopkins Hospital

15 Filed JUN 30 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 20, 19 21, to June 28, 19 21, that I last saw h.. alive on June 28, 19 21, and that death occurred, on the date stated above, at 12:15 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Nasal Diphtheria

(duration) yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann + Nasal Culture

(Signed) W Barnem M. D.

6-28-21, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUN 28 1921

20 UNDERTAKER: Commissioner Health,

ADDRESS

MORTUARY CLERK

Burial Permit Clerk

WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Inf of Harry & Margie Stubbs

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54992 ✓ D 54992

CERTIFICATE OF DEATH.

15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2922 Clifton Av ST.: 15 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 2922 Clifton Av. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	WH	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Harry N. Stubbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Margie Wiley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Md.

14 Informant Harry N. Stubbs (Address) 2922 Clifton Av.

15 Filed JUN 30 1921 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17

I HEREBY CERTIFY, That I attended deceased from June 29, 1921, to June 29, 1921, that I last saw h alive on June 29, 1921, and that death occurred, on the date stated above, at 5:52 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity, and a marginal detachment of placenta, of 2 mo. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6/29/21 (Address) 1605 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL

20 UNDERTAKER: Commissioner Health, — ADDRESS 1921 JUN 2

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54993 CERTIFICATE OF DEATH. 15 D 54993

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 525 Oxford St.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of James & Frances Henry

(a) RESIDENCE. NO. 525 Oxford ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ~~hrs.~~ or ~~min.~~
—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 800

(c) Name of employer

9 BIRTHPLACE (city or town) 525 Oxford St. City.
(State or country)

PARENTS

10 NAME OF FATHER Jas. Henry

11 BIRTHPLACE OF FATHER (city or town) N.Y.
(State or country)

12 MAIDEN NAME OF MOTHER Frances Wrider

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

11 Informant Elmira Hall
(Address) 525 Oxford st.

15 Filed JUN 30 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28/1921

17 I HEREBY CERTIFY, That I attended deceased from 6/28/1921, to 6/28/1921 that I last saw h alive on 6/28/1921 and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Not Known

CONTRIBUTORY (Secondary) Premature birth (duration) yrs. mos. 1 ds.

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John H. Tompkins M. D.

(Address) 1019 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JUN 2 1921

20 UNDERTAKER

ADDRESS

Commissioner Health.

BOARD OF HEALTH
Burial Permit Clerk

IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54994 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54994

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 S. Lakewood Ave ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Kurz

(a) RESIDENCE. NO. 526 S. Lakewood ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John L Kurz

6 DATE OF BIRTH (month, day, and year) Sept 11th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rosedale Md

PARENTS

10 NAME OF FATHER J. L. Langenfelder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carry Houston (Address) 126 Wells Glenburnie Pa.

15 Robert P. Harrison, Registrar

Burial Permit Clerk

JUN 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to June 29, 1921, that I last saw h[illegible] alive on June 28, 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) yrs. 7 mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis & Myocarditis insufficiency (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Alma B Dunnaway, M. D.

6/30/21 (Address) 748 N Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 1st 1921
20 UNDERTAKER Johannah Landes	ADDRESS 94 Aliceanna

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54995

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54995

8-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2101 Lamley ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Theresa Starklauf

(a) RESIDENCE. NO. 211 N. Gradavia ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) November 7-1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel Starklauf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Pearl McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Samuel Starklauf

(Address) 211 N. Gradavia

15 Filed Robert P. Harrison, Registrar

JN 30 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-21 19

17 I HEREBY CERTIFY, That I attended deceased from 5-30-21, 19, to 6-30-21, 19, that I last saw her alive on 6-30-21, 19, and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Bronch Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Whooping cough

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 2528 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul Cemetery	June 30 1921
20 UNDERTAKER	ADDRESS
Wm Christian Miller	2334 Jefferson

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 54996

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54996

105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 S. 6 Chester ST., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James M. McNeal

(a) RESIDENCE NO. 328 S. 6 Chester ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 22-1918

7 AGE: Years 2; Months 9; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Geo. B. McNeal

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Margaret Helm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Geo. B. McNeal (Address) 328 S. 6 Chester St

15 Filed ....., 19..... Registrar

Robert F. Harrison, Burial Permit Clerk.

JUN 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1921, to June 29, 1921, that I last saw him alive on June 29, 1921 and that death occurred, on the date stated above, at 12.05 A m.

The CAUSE OF DEATH* was as follows:

Gastero Enteritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Insolation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Geo. F. Keller, M. D.

6-30, 1921 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenbath Cemetery — DATE OF BURIAL July 1 1921

20 UNDERTAKER J. J. Moran — ADDRESS 3000 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54997

CERTIFICATE OF DEATH.

H 8

1-PLACE OF DEATH Church Home Infirmary

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas. T. Chambers

(a) RESIDENCE NO. Church Home & Infirmary ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred A. Chambers dont know

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Minister

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotsbrow

PARENTS

10 NAME OF FATHER Scotsbrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotsbrow

12 MAIDEN NAME OF MOTHER Scotsbrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotsbrow

14 Informant (Address) Church Home Inf.

15 Filed JUN 30 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to June 28, 1921, that I last saw him alive on June 27, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Asthenia

(duration) 3? yrs. mos. ds.

CONTRIBUTORY (Secondary) arthritis deform

(duration) 10? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? physical exam.

(Signed) H. H. Hartt M. D.

19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md	June 30 1921
20 UNDERTAKER J G Moran	ADDRESS 3000 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic rheumatoid arthritis. No further history

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54998

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 869 N. Franklin St. ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius F. Berger.

(a) RESIDENCE. NO. 869 N. Franklin ST., 17 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 11. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~55~~	54	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Swindell & Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER August Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs. Ida Berger.
(Address) 869 N. Franklin St.

15 Filed JUN 30 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1921, to June 28, 1921, that I last saw h alive on June 28, 1921, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Ephanation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. F. Campbell M. D.

(Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 1 1921
20 UNDERTAKER	ADDRESS
Wm. F. McKewen Sons	North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

Longston

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54999 ~~D 54999~~

CERTIFICATE OF DEATH.

10-03

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1727 McCulloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Longston

(Residence in Baltimore: No. 1727 McCulloh St.; 36 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, ...1871...., 1 .....
(Month) (Day) (Year)

7-AGE, 50 ....yrs....mos....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. — Williams

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Belle Longston

(Address) 1727 McCulloh

15. JUL 1 1921 Filed....., 191 ROBERT A. BRUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1st, 1921, to June 27th, 1921, that I saw h.. alive on June 27th, 1921, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Pleurisy

(Duration) ....yrs. 2 mos.....ds.

CONTRIBUTORY (Secondary) Probably following

and tuberculosis

(Duration) ....yrs. mos.....ds.

(Signed) C. H. Jenkins M. D.

June 27, 1921. (Address) 922 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Ft. Auburn — DATE OF BURIAL, July 1, 1921.

20-UNDERTAKER Sam'l W. Isaac Son — ADDRESS 1400 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Not tuberculous

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

D 55000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55000

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 607 W Mulberry ST. 4 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Harvey

(Residence in Baltimore: No. 607 W Mulberry St St.; 11 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1875 (Year)

7-AGE, 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country). Don't Know

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country). Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Wright

(Address) 607 W Mulberry

15- Filed JUL 1 1921 191.... ROBERT S. BRUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know of any

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch M. D. (Coroner.)

6-30 1921 (Address) 117 W Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, July 2, 1921

20-UNDERTAKER Wm. H. Rose & Son — ADDRESS 400 Madison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55001

D 55001

CERTIFICATE OF DEATH.

REGISTERED NO. C 38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maud Boyd

(Residence in Baltimore: No. 703 N. Fowler St. 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Male~~ Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1883
(Month) (Day) (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 027

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. James Randolph

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Martha Jordan

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emory Boyd

(Address) 703 N. Fowler

15- JUL 1 1921 191.... ROBERT ... UTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6 (Month) 28 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 19 1921, to June 28 1921, that I saw h[illegible] alive on June 28 1921, and that death occurred, on the date stated above, at 2.20 p m.

The CAUSE OF DEATH* was as follows: Toxic de[illegible] Myocarditis
Disease Myocardium
Contributory Pulmonary tuberculosis

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) John C. Stewart M. D.

6-29-21, 191.. (Address) 710 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Pt. Breeze Cem

DATE OF BURIAL. July 1, 1921

20-UNDERTAKER Sam'l. H. Chase & Son

ADDRESS 1100 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Boson

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108 D 55002

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE. (No. South Balto., Hosp ST. 24 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerhardt Bossaus

(a) RESIDENCE. No. 1142 Cookie St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 11 mos. (Life) ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: W'h
5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July - 1918

7 AGE: Years 2 | Months 11 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child. 000
(b) General nature of industry, business, or establishment in which employed (or employer): C
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md

PARENTS
10 NAME OF FATHER: Gerhardt Bossaus
11 BIRTHPLACE OF FATHER (city or town) (State or country): Holland
12 MAIDEN NAME OF MOTHER: Margoretha ~~Dieck~~ Schmidt
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungary

14 Informant: Mother (Mrs Mary Bossaus)
(Address) 1142 Cookie St

15 Filed JUL 1 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 26 1921 June 29 1921
that I last saw h alive on 6/29 1921
and that death occurred, on the date stated above, at 8 30 P m.
The CAUSE OF DEATH* was as follows:
Peritonitis, acute,
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Appendicitis acute
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1142 Cookie St.
Did an operation precede death? yes Date of
Was there an autopsy? yes Autopsy
What test confirmed diagnosis?
(Signed) R. Abrahamson, M. D.
, 19 (Address) St Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Paul Cem
DATE OF BURIAL: July 1 1921
20 UNDERTAKER: John Henning & Co
ADDRESS: 2008 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55003

CERTIFICATE OF DEATH.

147 D 55003

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 43 Forman Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. C. Kraner

(a) RESIDENCE. No. 43 Forman Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Kraner

6 DATE OF BIRTH (month, day, and year) March 8-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	22	

8 OCCUPATION OF DECEASED 063

(a) Trade, profession or particular kind of work Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer) A Hoen & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Howard K Kraner (Address) 43 Forman Ave

15 JUL 1-1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to June 30, 1921, that I last saw h alive on June 29, 1921, and that death occurred, on the date stated above, at 3:10 A. m.

The CAUSE OF DEATH* was as follows:

Senile Gangrene

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Septic Gangrene

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Norwood M. D.

19 (Address) 1939 W Fayette

June 3

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 2 1921
20 UNDERTAKER	ADDRESS
Geo. Lehmab & Bro	201 Pulaski

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—S 24-14—M. & T.—2000 Bks.

D 55004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55004

CERTIFICATE OF DEATH.

9th Nov 1920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 150 Berlin St St. 23rd WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob. arnold

(Residence in Baltimore: No. 150 Berlin St. Ind Wards St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, March (Month) 1 (Day), 1837 (Year)

7-AGE 84 yrs. 3 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 900

9-BIRTHPLACE, (State or Country) Baltimore City.

PARENTS.

10-NAME OF FATHER, Franklin arnold.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Susie Rubert.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph A. Arnold

(Address) 230 Main st Ind Wards

15- Filed JUL 1 - 1921, 191 ROBERT A KRAUTER Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 29 (Day), 1921 (Year).

17. I HEREBY CERTIFY, That I attended deceased from June 21 1921, to June 29 1921, that I saw h im alive on June 29 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. 6 mos. ds.

(Signed) H Hammond Hagner M. D.

June 30, 1921 (Address) Catalaud, Annex.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, London Park — DATE OF BURIAL, July 2, 1921

20-UNDERTAKER Geo. L. Schwab & Bro — ADDRESS 201 Park Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55005 1426 CERTIFICATE OF DEATH. D 55005

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426 Holbrook ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank S. Haas

(a) RESIDENCE. NO. 1426 Holbrook ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs — mos. ds. How long in U. S., if of foreign birth? 46 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mr. Katherine Haas

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheelwright 107

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Valentine Haas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Katherine Haas

(Address) 1426 Holbrook St

15 Filed JUL 1 - 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10th 1917 to June 29 1921.

that I last saw h... alive on June 29 1921.

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

I. Cancer Face

(duration 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

June 29, 19 (Address) 1504 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 2 1921
20 UNDERTAKER	ADDRESS
Henry Hoult Sons	1301 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic.

D 55006

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55006

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Volunteer Hospital or Sepulchre St. 18 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Condon
(Residence in Baltimore: No. 920 W Lombard St. Unknown St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, ...56....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Laborer.....
(b) General nature of industry, business, or establishment in which employed (or employer).....040.....

9-BIRTHPLACE, (State or Country). N. Jersey

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Minnie Kohler
(Address) 3704 Calloway ave.

15- Filed JUL 1 - 1921, 19.. ROBERT P. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jun., 30., 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Coroner, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Valvular Heart disease
(Duration) Don't Know yrs. mos. ds.
CONTRIBUTOR (Secondary) Probably Heart
(Duration) yrs. mos. ds.
(Signed) H. K. Gorman M. D.
(Coroner.)
7-1, 1921 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Bon Secours Cemetery
DATE OF BURIAL, July 2 1921

20-UNDERTAKER Wm. Cook
ADDRESS 502 E Lord

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55007

CERTIFICATE OF DEATH.

104 D 55007

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 Wilkens ave ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaretta Mary Watkins

(Residence in Baltimore: No. 2206 Wilkens ave St.; 69 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November 1, 1926
(Month) (Day) (Year)

7-AGE, ... yrs. 8 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, Edward J. Watkins

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Annie J. Reardon

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Edward J. Watkins

(Address) 2206 Wilkens Ave

15- Filed JUL 1 - 1921, 191.. ROBERT J. KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 29 1921, to June 30 1921, that I saw h.. alive on June 30 1921, and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Thos. F. Mitchell M. D.

June 30, 191.. (Address) 515 Walbrook

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL New Cathedral — DATE OF BURIAL July 1, 191..

20-UNDERTAKER A. S. Marshall — ADDRESS 3539 Fall Rd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55008

CERTIFICATE OF DEATH.

47 D 55008

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 4015 Ashburton Al ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Foley

(a) RESIDENCE. NO. 401 S. Ashburton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of): James Foley

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 74 yrs. | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: ~~Wm~~ Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Patrick J. Foley (Address) 405 S. Aisburton Al

15 JUL 1 - 1921 ROBERT J. KRAUTER Registrar Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 22 1921, to June 29, 1921, that I last saw h[illegible] alive on June 28 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? Date of ~

Was there an autopsy? ~

What test confirmed diagnosis? ~

(Signed) M A O'Neill, M. D.

6/26, 1921 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem — DATE OF BURIAL: July 2 1921

20 UNDERTAKER: John J Cowan & Son — ADDRESS: 901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55009

CERTIFICATE OF DEATH.

120 ✓ D 55009

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Jessup

(a) RESIDENCE. NO. 1011 Watson St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed JUL 1 - 1921 MOTHER'S [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1921, to June 27, 1921, that I last saw her alive on June 26, 1921, and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis.
(No cerebral Hemorrhage?)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) W. H. Eaman, M. D.

6-27-21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 1st 1921
20 UNDERTAKER	ADDRESS
Joseph a Farrell	2319 Division

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55010

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 55010

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 E. Clement St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Johnston

(a) RESIDENCE. No. 121 E. Clement ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ James B. Johnston

6 DATE OF BIRTH (month, day, and year) Sept. 6. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Mears

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary M. Cosdet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Catherine Joyce

(Address) 426 Light St.

15 Filed JUL 1 - 1924 ROBERT S. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1921, to June 30 1924, that I last saw her alive on June 29 1921, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis and myocarditis, unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. & urinary

(Signed) Wm. Stifler, M. D.

6/30 1924 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	July 4, 1924
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55011

CERTIFICATE OF DEATH.

120 D 55011

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2546 Frederick Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Schaeffler

(a) RESIDENCE. No. 2546 Frederick St. Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 40 mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schaeffler

6 DATE OF BIRTH (month, day, and year) Sept. 27th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10		

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Widand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Kiger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Louis Mrozynski 2546 Frederick Ave

15 Filed JUL 1 - 1921 19 ROBERT I. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1920, to June 29, 1921, that I last saw her alive on June 28, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Astero Sclerosis, Chr Interstial Nephritis. Endocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert C Mitch M. D.

6/29, 1921 (Address) 215 Milton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 1, 1921

20 UNDERTAKER Margaret L. Flynn ADDRESS 1422 Eight St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT WRITE IN THIS SPACE RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55012

CERTIFICATE OF DEATH.

D 55012

REGISTERED NO. 23.184

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Light St. WARD 23)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lester LeRoy Wickless

(a) RESIDENCE. No. 1716 Light St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1st 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Charles H. Wickless

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Annie M. Nagel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Charles H. Wickless (Address) 1716 Light St.

15 Filed JUL 1 - 1921 ROBERT J. KRAUTZ Registrar

Burial Permit Oliver

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 29, 1921, that I last saw h[illegible] alive on June 29, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. S. Campbell M. D.

(Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	July 1, 1921
20 UNDERTAKER	ADDRESS
Margaret L. Flynn	1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55013

28 D 55013

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1539 Covington St. ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Norman Smith

(a) RESIDENCE. No. 1539 Covington St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? 31 yrs. 4 mos. 27 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Cora M. Smith

6 DATE OF BIRTH (month, day, and year) Feb 3 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	4	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boiler Maker 073
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O R. R.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry F. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Eveline Durner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

14 Informant Henry F. Smith
(Address) A. A. Co. Md.

15 Filed JUL 1-1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1921, to June 30, 1921, that I last saw him alive on June 30, 1921, and that death occurred, on the date stated above, at 11 55 a. m.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
Unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) M. L. Steger, M. D.

7/1. 1921 (Address) 1319 Lighter St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	July 2 1921

20 UNDERTAKER J. Fenw. McCully ADDRESS 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of PLACE OF DEATH is very important. See instructions on back of certificates.

DO NOT FOLD FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

D 55014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55014

CERTIFICATE OF DEATH.

OK I A K Gorsuch

164

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 N. Appleton ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Marshall

(Residence in Baltimore: No. 32 N. Appleton St.; ... yrs., ... mos., ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, unknown (Month) (Day) (?) (Year)

7-AGE, 16 yrs. ... mos. ... da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. domestic
(b) General nature of industry, business, or establishment in which employed (or employer). ...

9-BIRTHPLACE, (State or Country). unknown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Taylor

(Address) 32 N. Appleton St

15-

Filed JUL 1 - 1921 191...

[redacted] Burial Permit No. [redacted]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6 (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6-26-21 191..., to 6-30-21 191...,

that I saw h[illegible] alive on 6-30-21 191...,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Ptomaine Poisoning

Heat

(Duration) ... yrs. ... mos. 5 da.

CONTRIBUTORY (Secondary) Excessive heat, diet

Gen'l Debility (Duration) ... yrs. ... mos. 7 da.

(Signed) F. H. Cardozo M. D.

6-30-21 191... (Address) 1524 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cemetery

DATE OF BURIAL. 7/1, 1921

20-UNDERTAKER Mrs. Gotthofer

ADDRESS 406 N. Carey St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Remarks Food or fish caused poisoning unknown

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55015

CERTIFICATE OF DEATH.

D 55015

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1632 N. Mount ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Camilla Bankins

(a) RESIDENCE. NO. 1632 N Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Basil Bankins

6 DATE OF BIRTH (month, day, and year) Dec. 27. 1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-Wife DOD

(b) General nature of industry, business, or establishment in which employed (or employer) Nonel

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Francis Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co.

12 MAIDEN NAME OF MOTHER Harriet Warrator

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co. Md

14 Informant Mrs Marie Stevens

(Address) 1630 Argyle ave

15 Filed JUL 1-1921 [illegible] Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 6. 1919. to June 29. 1921.

that I last saw h[illegible] alive on June 26. 1921.

and that death occurred, on the date stated above, at 6.05 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 6 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. McC Cooper Wright M. D.

(Address) 2005 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Co Md	July 2 1921

20 UNDERTAKER R C Gross ADDRESS 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55016

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305, Linden Ave ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Reynolds

(a) RESIDENCE. No. 1305 Linden Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

11.8 mo

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Nora L. Reynolds

6 DATE OF BIRTH (month, day, and year) Jun 21. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lawyer D42
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Reynolds

11 BIRTHPLACE OF FATHER (city or town) Roxbury (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Rosanna Ewell

13 BIRTHPLACE OF MOTHER (city or town) Prince William Co (State or country) Virginia

14 Informant Nora L. Reynolds
(Address) 1305 Linden Ave

15 Filed JUL 1 - 1921 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 26. 1921. to June 29. 1921.
that I last saw ~~him~~ her alive on June 29. 1921.
and that death occurred, on the date stated above, at 11 0 m.
The CAUSE OF DEATH* was as follows:

General paralysis change
very gradual
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypostatic pneumonia with
(duration) yrs. mos. 2 ds.

18 Where was disease contracted
If not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical findings

(Signed) E. E. Gilbert M. D.
19 (Address) 1006 Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	July 2 1921

20 UNDERTAKER ADDRESS
John B. Spence 1325 N Caroline St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PREPARED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55017

CERTIFICATE OF DEATH.

1 2 D 55017

(PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. Mpersity Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Garfield Williams

(Residence in Baltimore: No. Dont Know

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Dont Know

6-DATE OF BIRTH, ... Dont Know, 1 .....
(Month) (Day) (Year)

7-AGE, 25 yrs Dont Know mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, - - -

11-BIRTHPLACE OF FATHER (State or Country), - -

12-MAIDEN NAME OF MOTHER - -

13-BIRTHPLACE OF MOTHER (State or Country), - -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-
JUL 1 - 1921
191.... ROBERT I BRAUTE
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquiry~~) thereon and from the evidence obtained by said ..... (Inquest, autopsy ~~or inquiry~~) ..... find that said deceased came to Lucy death on the day stated above.

THE CAUSE OF DEATH* was as follows:

bullet wound in abdomen & chest

a few hours
(Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) shot by James Bagley a few hours

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) W K Forman M. D.
(Coroner.)

6-30, 1921. (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY.

DATE OF BURIAL, JUL 1 - 1921, 19....

20-UNDERTAKER

ADDRESS

Commissioner of Health,

Dep. Wm. F. WOODALL.

Dosh

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55018

CERTIFICATE OF DEATH.

X 91 D 55018

1-PLACE OF DEATH Baltimore Md

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Phipps Clinic Johns Hopkins Hosp ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Dosh

(Residence in Baltimore: No. Owings Mills Md St.; .....yrs., 2 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	widowed

6-DATE OF BIRTH, May (Month) 6 (Day) 1858 (Year) April

7-AGE, 63 yrs. 1 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter D.N.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Carpenter

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER, John Dash

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Isaacson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leslie B. Hohman

(Address) Johns Hopkins Hosp

15-

Filed JUL 1-1921, 191..... ROBERT I. TRAIL Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 30th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~April~~ June 13 1921, to June 30 1921, that I saw h im alive on June 30 1921, and that death occurred, on the date stated above, at 2.05 p m.

The CAUSE OF DEATH* was as follows:

Manic depressive Insanity (Raymond Farm)

(Duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) — yrs. — mos. 7 ds.

(Signed) Leslie B. Hohman M. D.

June 30, 1921 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 17 ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Owings Mills Md

Former or usual residence Owings Mills Md

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Chapel-Hazlewood Md DATE OF BURIAL, July 2 1921

20-UNDERTAKER Ed Tyson & Son ADDRESS 1423 N. Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Remarks

Not Luetic

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55019

D 55019 HEALTH DEPARTMENT—CITY OF BALTIMORE

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 N. Durham ST.; 8 WARD)

2-FULL NAME Joseph Schillinger

(a) RESIDENCE. No. 1706 N. Durham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of ~~(or WIFE of)~~ Elvira Schillinger

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) ON

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown Schillinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Elvira Schillinger 1706 N. Durham st

15 Filed JUL 1-1921 ADELE I KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1921

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1921, to June 30, 1921, that I last saw him alive on June 30, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Apoplexy (Embolism)

(duration) ... yrs. ... mos. 24 ds.

CONTRIBUTORY (Secondary) acute dilation of Heart

(duration) ... yrs. ... mos. 24 hrs

18 Where was disease contracted, if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Thos F. Stapleton, M. D.

(Address) June 30 21 2866 Linford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery	July 2nd 1921

20 UNDERTAKER ADDRESS

George Schillinger

CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Warrenweteh

D 55020 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

64 D 55020

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2406 Woodbrook ave ST.; 13 WARD)

2-FULL NAME Carine F. Hammerstat

(a) RESIDENCE. No. 2406 Woodbrook ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? — yrs — mos — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846 Aug 6th

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto-Md

PARENTS

10 NAME OF FATHER Charles Hammerstat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Peppler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Kroul
(Address) 2410 Woodbrook

15 Filed JUL 1-1927, 19.....

ROBERT I. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6.30 1927

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1927, to June 30, 1927, that I last saw h.er alive on June 29, 1927, and that death occurred, on the date stated above, at 9.20 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy. Cerebral Hemorrhage (Paralysis) 2nd Stroke.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) Several years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. C. Poe, M. D.

, 19 (Address) 2034 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 2nd 1927

20 UNDERTAKER ADDRESS

H. Maurice Poulson Fatte & Bentalou

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55021

D 55021

CERTIFICATE OF DEATH

Sr Hanna 1822 W Balto St

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 534 S Bentalou ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy R Leighton

(a) RESIDENCE. NO. 534 S Bentalou WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26/21

7 AGE: Years — Months — Days 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm. F. Leighton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lucille Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Wm F Leighton 534 S Bentalou St

15 Filed JUL 1 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1921

17 I HEREBY CERTIFY, That I attended deceased from June 26 1921 to June 30 1921

that I last saw h[illegible] alive on June 30 1921.

and that death occurred, on the date stated above, at 8.30P m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(about 6½ Mos)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J J Hanna, M. D.

19 (Address) 1822 W Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery DATE OF BURIAL: June 19 21

20 UNDERTAKER: H. D. Shepherd ADDRESS 923 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Ricka W. Hines

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55022

CERTIFICATE OF DEATH.

D 55022

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. Woman's Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Ricka Weigleir Hines

(Residence in Baltimore: No. Wadsworth ~~Ave~~ Chelsea Terrace near Clifton Ave. St.; 75 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F	white	Married

6-DATE OF BIRTH, Oct. (Month) 4th (Day), 1845 (Year)

7-AGE, 75 yrs. 8 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Aaron Weigleir

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Rebecca ~~Ricka~~ Weigleir

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aaron W. Hines

(Address) Wadsworth Ave. Baltimore Md.

15- JUL 1-1921 Filed....., 191.... ROBERT I KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 22 1921, to June 30, 1921, that I saw h er alive on June 30 1921, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(Duration) 1 yrs. mos. ds.

(Signed) Nora B. DeVilbiss M. D.

June 30, 1921 (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 3d ....ds. In the State 75 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Wadsworth Ave.

Former or usual residence Wadsworth Ave.

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Oheb Shalom	7-3, 1921
20-UNDERTAKER Herd Sandheim	ADDRESS 118 W. Mt Royal

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 55023

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55023

CERTIFICATE OF DEATH.

30

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3501 Hudson ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tillie M. Stricker

(Residence in Baltimore: No. 3501 Hudson St.: 1 yrs., 5 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH, January 5th, 1920 (Month) (Day) (Year)

7-AGE, 1 yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Frederick Stricker

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Margaret Stricker

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Pholonia Stricker

(Address) 3501 Hudson St.

15- JUL 1 1921 Filed ..... 191.... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 27 1921, to June 30th 1921, that I saw her alive on June 29th 1921, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

Indefinite (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....(Duration) ....yrs. ....mos. ....ds.

(Signed) Jos. J. Lochbaker M. D.

June 30, 1921. (Address) 806 S. 32nd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, July 1, 1921.

20-UNDERTAKER Lilly & Fiske ADDRESS 503 S. Mo...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55024

CERTIFICATE OF DEATH.

179 ✓ D 55024

1-PLACE OF DEATH West End Maternity Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 112 N. Calhoun St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Eubank

would be Kilmarnock Va

(a) RESIDENCE NO. ST., WARD West End Maternity

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. / Md

PARENTS

10 NAME OF FATHER Gordon Eubank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Co. Va

12 MAIDEN NAME OF MOTHER Gazella Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Middlesex Co. Va

14 Informant Miss Mary F Palmer

(Address) Friends Aid Dy. Hosp.

15 JUL 1 - 1921 ROBERT J. BRUTEN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1921

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1921, to June 30, 1921, that I last saw him alive on June 29, 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Heat stroke

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None except symptoms

(Signed) Bernard Brickell Hinson M. D.

6/30 1921 (Address) 103 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kilmarnock Lancaster Co. Va	July 2 1921
20 UNDERTAKER	ADDRESS
Wilbur W. Shriver	1018 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55025

CERTIFICATE OF DEATH.

X 40 ✓D 55025

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST.. 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claude L. Myers

(a) RESIDENCE. NO. Du Bois Pa ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Feb 11 1884

7 AGE — Years: 37 — Months: 3 — Days: 19 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm E. Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Corinne Wall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Louise D. Myers Du Bois Pa

15 Filed JUL 1 1921 ROBERT J. [illegible] Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1921, to July 1, 1921, that I last saw h alive on July 1, 1921, and that death occurred, on the date stated above at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiosclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 6/21/21

Was there an autopsy? No

What test confirmed diagnosis? P.M. Observation

(Signed) Frank C. Marini, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Du Bois Pa — DATE OF BURIAL: July 1 1921

20 UNDERTAKER: John A. Mitchell — ADDRESS: 120 W. Mt. Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Emma G Worman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55026

CERTIFICATE OF DEATH.

79 D 55026

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1102 Harlem Av ST.) 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. E. T. Worman

(Residence in Baltimore: No. 1102 Harlem Av St.: 11 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July 4 (Month) (Day), 1864 (Year)

7-AGE, 56 yrs. 11 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk 009 C.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Torsch Packing.

9-BIRTHPLACE, (State or Country), Fred. Co. Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary C. Brent

(Address) 1102 Harlem Ave

15- JUL 1 1921

Filed....., 191.....

MOTHER'S NAME

Burial ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1920, to June 29 1921, that I saw h.r alive on June 29 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

(Duration)..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ? yrs. ..... mos. ..... ds.

(Signed) W. R. Forbes M. D.

June 30, 1921 (Address) 6 E. Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mount Olivet Md DATE OF BURIAL, July 1, 1921

20-UNDERTAKER John O'Neill Co ADDRESS W. Fayette St

CAUSE OF DEATH must be plainly written, so that it may be properly important. See instructions on back of certificate.

Balthaser Prell

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55027

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Washington Ave No Washington

CITY OF BALTIMORE. (No. Mt Washington Ave ST.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Balthazer Prell

(a) RESIDENCE. NO. Mt Washington Md ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Prell

wife Maiden Name Not Known

6 DATE OF BIRTH (month, day, and year) May 1. 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or — min.
72	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) — 030

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edw Eder

(Address) Mt Washington

15 Filed JUL 1 1921 Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17

I HEREBY CERTIFY, That I attended deceased from March 21. 1921. to June 29. 1921.

that I last saw him alive on June 29, 1921.

and that death occurred, on the date stated above, at 2P. m.

The CAUSE OF DEATH* was as follows:

Malignant Papilloma of Bladder

— (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Surgical Operation "Appropriate Symptoms" March 23/21 (duration) yrs. 3 mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of March 23/21

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) John J. Ennis M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel.	July 2 1921
20 UNDERTAKER E A Wiedefeld Jr	ADDRESS 501 E 22

ROBERT I. KRAUTZ

Burial Permit Clerk

(Bond)

D 55028 HEALTH DEPARTMENT—CITY OF BALTIMORE 28 D 55028

CERTIFICATE OF DEATH.

REGISTERED No. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. 233 Poppleton St. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo A Bond

(Residence in Baltimore: No. 233 N. Poppleton St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1874 (Year)

7-AGE, 27 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Geo A Bond Sr.

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER, Amanda Thomas

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amanda Bond

(Address) 233 N. Poppleton St.

15-

Filed ..... 191.. Robert P. Harrison, Registrar.

JUL 1 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) ~~and~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) ..... M. D.
Coroner

6-30, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn

DATE OF BURIAL, June 3 1921

20-UNDERTAKER Brown & Sheeland

ADDRESS 114 N Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 55029 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55029

CERTIFICATE OF DEATH.

1-PLACE OF DEATH USPHS Hosp. #56,

CITY OF BALTIMORE: (No. Ft.McHenry,Balto.,Md. ST., 24 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gregory,

(a) RESIDENCE NO. USPHS Hosp. #56 Ft.McHenry,Baltimore,Md. STREET
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or .... min.
	29			

8 OCCUPATION OF DECEASED Fireman

(a) Trade, profession or particular kind of work ---

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Gregory

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Edgar T. Rosenbrock
(Address) USPHS Hosp. #56 Ft. McHenry, Md.

15 Filed ....., 19 .... Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 1921.

17 I HEREBY CERTIFY, That I attended deceased from 6/26/21 to 6/30/21 .

that I last saw him alive on June 30, 1921.

and that death occurred, on the date stated above, at 1:45 p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, chronic, pulmonary, advanced active

2 yrs (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) -- (duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Exam. lab. report

(Signed) J. D. Pritchard M. D.
P.A. Surgeon

, 19 (Address) USPHS Hosp. #56 Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Littleton, N. C. DATE OF BURIAL: July 1 1921

20 UNDERTAKER: Sol Lennon ADDRESS 1127 E Bulte St

1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be given. Abbreviations should be carefully avoided. Note that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55030 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55030

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 N. Madeira ST.; 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincenz Zujic

(Residence in Baltimore: No. 805 N. Madeira St.; 50 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ married (Write the word.)

6-DATE OF BIRTH, Aug. 28, 1862 (Month) (Day) (Year)

7-AGE, 59 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Tailoring

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Zujic

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Anna Hanousek

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ana Marie Zujic

(Address) 805 N. Madeira St.

15- Robert P. Harrison,

Filed JUL 1 1921, 191.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 29, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 12, 1921 to June 29, 1921, that I saw him alive on June 28, 1921, and that death occurred, on the date stated above, at 11 2 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) — yrs. 3 mos. — ds.

(Signed) F. J. Siebold M. D.

June 30, 1921, (Address) 1001 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bay Hill

DATE OF BURIAL, July 2, 1921

20-UNDERTAKER Frank Enoch & Son

ADDRESS 1706 Eastland Av

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55031

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay Vist. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Mahoney

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospitals.

15 Filed ... 19 Robert P. Harrison, Registrar

L 1 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1921

17 I HEREBY CERTIFY, That I attended deceased from January 27, 1921. to June 30. 1921.

that I last saw h... alive on June 30. 1921.

and that death occurred, on the date stated above, at 10:45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? yes Autopsy

What test confirmed diagnosis?

(Signed) Clyde O'Neill M. D.

7/1/21 (Address) New City Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	7-2 1921
20 UNDERTAKER John H. Troadmore	ADDRESS 142 Lexington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55032 HEALTH DEPARTMENT—CITY OF BALTIMORE 120 D 55032

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2122 E Biddle St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna May Rambo

(Residence in Baltimore: No. 2122 E. Biddle St. St.; 37 yrs., 6 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Dec 9 (Month) (Day), 1883 (Year)

7-AGE, 37 yrs. 6 mos. 21 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Geo S. Carrol

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Maggie Miller

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rambo

(Address) 2122 E. Biddle St.

15-

Filed....., 191... Robert P. Harrison, Registrar.

L 1 - 1921 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1919, to June 30 1921, that I saw h[er] alive on June 30 1921, and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Hypertrophy, Arteriosclerosis, Arteriosclerosis Interstitial Nephritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration).....yrs.....mos.....ds.

(Signed) Clara Summers M. D.

June 30, 1921. (Address) 4706 Harford Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Balto. Cem. | DATE OF BURIAL, July 2, 1921.

20-UNDERTAKER Henry Lutz | ADDRESS 1007 N. Bond St.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 55033

CERTIFICATE OF DEATH

92 D 55033

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 433 N. Carey St.: 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Dora Verna Schultz

(Residence in Baltimore: No. 433 N. Carey St.: \ yrs. 18 mos. \ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March (Month) 5 (Day), 1903 (Year)

7 AGE: 16 yrs. 3 mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jacob Schultz

11 BIRTHPLACE OF FATHER (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Pearl Bradbennick

13 BIRTHPLACE OF MOTHER (State or country): Mich

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pearl Schultz

(Address) 433 N. Carey St

15 ..... 191.....

Robert P. [illegible]ton,
Registrar

Clerk

1-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 30 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1921, to June 30 1921, that I saw h[illegible] alive on June 30, 1921, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds

Contributory (SECONDARY) Edema of Lungs 3 hrs

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Grant M. D.

..... 191 .... (Address) 2226 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Friendship Cem. Md. [illegible]

DATE OF BURIAL: July 2 1921

20 UNDERTAKER: W. J. Tickner Sons

ADDRESS: North & Fremont Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55034

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO. 4 × 120

CITY OF BALTIMORE: (No. ..... ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noah W Brown.

(a) RESIDENCE. No. Howard Co, Md ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Brown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland Howard Co.

PARENTS

10 NAME OF FATHER Joel Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Jack Brown. (Address) 4008 Falls Road

15 Filed JUL 2 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1921, to July 1, 1921, that I last saw h.. alive on July 1, 1921, and that death occurred, on the date stated above, at 1:10 a. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. Facts Symptoms

(Signed) John S Fowler, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	July 2 19 21
20 UNDERTAKER	ADDRESS
Ehenowith & Son	Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. This is a permanent record. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55035 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55035

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Bethel st ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Pitts

(a) RESIDENCE. NO. 519 Bethel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno Pitts

6 DATE OF BIRTH (month, day, and year) dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work-037

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St-Marys Co Md

Lived in Balt 38 years

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Virgie Pitts (Address) 519 N Bethel st

15 Filed JUL 2 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16th, 1921, to June 30th, 1921, that I last saw h alive on June 29, 1921, and that death occurred, on the date stated above, at 2:00 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

A Hypatitis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W W Butler M. D.

. 19 (Address) 2801 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt-Olivet Cem

DATE OF BURIAL July 3 1921

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. be so that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

149/30 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 55036

30

D 55036

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Johns Hopkins Hospital ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mariam Hawkins

(a) RESIDENCE. NO. 30 S. Register ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7- 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm Hawkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Washington DC

12 MAIDEN NAME OF MOTHER Mary Drake

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

Filed JUL 2 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29- 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27- 1921, to June 29- 1921, that I last saw h. Emalive on June 29- 1921, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) ....yrs. ....mos. 2 days.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Lumbar puncture

(Signed) W Davison, M. D.

6-30-21 19 (Address) J H H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery.	July 2 1921

20 UNDERTAKER Milton Davis ADDRESS 313 N Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55037

CERTIFICATE OF DEATH.

X 91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 W. Conway ST. 32 WARD)

2-FULL NAME Benjamin Lancaster

(a) RESIDENCE. NO. 10 W. Conway ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct, 17, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Penna.

PARENTS

10 NAME OF FATHER Benjamin Lancaster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Helen Boiseve

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co maryland.

14 Informant Henrietta Moulden

(Address) 10 W. Conway St

15 [illegible] Robert P. Harrison, Registrar

2-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 30 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 25, 1921, to June, 28, 1921, that I last saw him alive on June, 28, 1921, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) no other cause ascertained

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no —

What test confirmed diagnosis? —

(Signed) Dan Franchini, M. D.

7/1, 1921 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn St	July 2 1921
20 UNDERTAKER	ADDRESS
N. L. Brown and Son	1081 W. Mont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55038 ✓ D 55038

CERTIFICATE OF DEATH.

108

REGISTERED NO.....

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 1 ST.; ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rowland Eckels.

(a) RESIDENCE. NO. 2939 Eastern Ave, WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs — mos — ds How long in U. S., if of foreign birth? — yrs — mos — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 21-1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. Eckels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Florence Frkh.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

11 Informant Florence Eckels

(Address) 2939 Eastern ave.

15 Filed [illegible], 19 P. Harrison, Registrar

2 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1921

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1921, to July 1, 1921, that I last saw him alive on July 1, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute gangrenous appendicitis Ruptured

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Toxemia peritonitis.

(duration) yrs. 12 hrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes. Date of 6/30/1921

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) Phil S. Brown M. D.

. 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	July 3 1921

20 UNDERTAKER Wm. E. Black ADDRESS 927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55039

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55039

CERTIFICATE OF DEATH.

14

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 237 N. Carey ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Elizabeth Rutherford

(a) RESIDENCE. No. 237 N. Carey St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22 1875

7 AGE — Years: 46 — Months: — — Days: 22 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Alexander Rutherford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Ellen Keith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Ellen M. Carter 714 G St. S.E. Washington D.C.

15 Filed , 19 Registrar

JL 2-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1921

17 I HEREBY CERTIFY, That I attended deceased from June 25, 19 21 to June 29, 19 21.

that I last saw h er alive on June 29, 19 21.

and that death occurred, on the date stated above, at 4 20 A. m.

The CAUSE OF DEATH* was as follows:

Acute dysentery

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exposure heat.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Anna J. McCampbell M. D.

, 19 (Address) 1316 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 2 1921

20 UNDERTAKER: Jos Block ADDRESS 1032 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Airey)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 55040

CERTIFICATE OF DEATH.

30 D 55040

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2665 Hilkens Ave ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Gordon Airey

(a) RESIDENCE. NO. 2665 Hilkens Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James A Airey

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Stathers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant James A Airey
(Address) 2665 Hilkens Ave

15 Filed 2-1921 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 25 1921, to July 1 1921, that I last saw h.. alive on July 1 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hans Boyd, M. D.

(Address) 612 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 4 1921
20 UNDERTAKER	ADDRESS
Jos B Cook	1003 N Balto St

Spec.—8-24-14—M. & T.—2000 Blks.

D 55041

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55041

CERTIFICATE OF DEATH.

41

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bridges Sullivan Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie Deep

(Residence in Baltimore: No. 35 N Linwood ave. St.; 52 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F	W	

6-DATE OF BIRTH. March 1, 1869.
(Month) (Day) (Year)

7-AGE. 52 yrs. 3 mos. 29 ds. If LESS than 1 day, ... hrs. or .... mts.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic Duties
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Andrew Meise

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Barbara Lippel

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Deep

(Address) 35 N. Linwood Ave.

15-

Filed ..... Robert P. Harrison, ... 191.....
Registrar.

~~1921~~ Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1921, to June 30 1921, that I saw h[illegible] alive on June 30 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cecum

(Duration) 1 yrs. 3 mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) August Koon M. D.

June 30, 1921. (Address) 4 E 25 St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 3 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 35 N Linwood Ave

Former or usual residence 35 N Linwood Ave

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	July 3rd, 1921
20-UNDERTAKER	**ADDRESS**
Fredk Lissau & Sons	Fallston Md

CAUSE OF DEATH in plain terms, as full as may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55042

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55042

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 767 Vine ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Brown

(a) RESIDENCE. No. 767 Vine ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifen ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 086

(b) General nature of industry, business, or establishment in which employed (or employer) Express

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Benjamin Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gertrude Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Marie Smith
(Address) 767 Vine St

15 Filed 7/2 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 11 1921. to June 30. 1921.

that I last saw him alive on June 29. 1921.

and that death occurred, on the date stated above, at 8:15 a m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) Indef. yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Regan

(Signed) W. H. Noville M. D.

1921 (Address) 767 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 2 1921

20 UNDERTAKER Lamb & Hemsley ADDRESS 1 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Mc Enerey)

D 55043

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55043

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth McInerney.

(a) RESIDENCE. NO. Preston Valley Hts ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John McInerney.

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Flannigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sister Florence. (Address) Preston & Valley Sts.

15 Filed JUL 2-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1921

17 I HEREBY CERTIFY, That I attended deceased from No record . 19 . to . 19 .

that I last saw her alive on June 26 . 1921 .

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

July 2 . 1921 (Signed) F. A. Warner, M. D.

(Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	July 2 1921
20 UNDERTAKER	ADDRESS
E. L. Fanning & Son	1386 Lafayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55044 ✓ D 55044

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2510 E Biddle ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank O Richardson

(a) RESIDENCE. No. 2510 E. Biddle ST., 8 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Augusta D. Richardson

6 DATE OF BIRTH (month, day, and year) Sept 9 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65.	65	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter. 75

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Evans Marble Yard West River Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Thomas L Richardson

11 BIRTHPLACE OF FATHER (city or town) West River Md

12 MAIDEN NAME OF MOTHER Elizabeth Watkins

13 BIRTHPLACE OF MOTHER (city or town) West River Md (State or country)

14 Informant John St Lowe (Address) 619 S Paca St

15 Filed 2-1921 Robert P. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 7 . 1920 . to July 1 . 1921 . that I last saw him alive on June 30 . 1921 . and that death occurred, on the date stated above, at 4. 40 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Enteritis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) B F Harrison M. D.

7/1 . 1921 (Address) 1305 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 4th 1921
20 UNDERTAKER	ADDRESS
E. D. Fanning Asst	1938 E. Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55045 HEALTH DEPARTMENT—CITY OF BALTIMORE. ✓ D 55045

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Club Road Roland Park. St.: 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Spencer

(a) RESIDENCE. No. 207 Club Road Roland Park. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Wales.

6 DATE OF BIRTH (month, day, and year) Oct 5, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired ooo

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Henry Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Wales

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant George H. Enos (Address) 1007 Cathedral St.

15 Filed 2-1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1921

17 I HEREBY CERTIFY, That I attended deceased from December, 1920, to July 1, 1921, that I last saw him alive on July 1, 1921, and that death occurred, on the date stated above, at 7 40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis Fibrosa

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) George H. Enos, M. D.

, 19 (Address) 1007 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	July 4 1921

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1827 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

August Lukaszewski.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55046

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55046

CERTIFICATE OF DEATH.

154 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 517 So. Bradford ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Lukaszewski

(a) RESIDENCE. NO. 771 Bush ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 5. 1834.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. John Carragan (Address) 519 S. Bradford St.

15 Filed Robert P. Harrison, Registrar

2-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 - 1921.

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to July 1, 1921, that I last saw h— alive on July 1, 1921, and that death occurred, on the date stated above, at 9:20 P. M.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) ....yrs. 5 mos. ....ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Weaver, M. D.

July 4 1921 (Address) 1 E Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem.

DATE OF BURIAL July 4" 1921

20 UNDERTAKER M. J. Sadowski.

ADDRESS 703 S. Ann

Mary Elvira.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55047

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55047

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 313 S. Madeira ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Girza.

(a) RESIDENCE. NO. 313 S. Madeira ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) Baltimore. (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Girza.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Julia Druet.

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Frank Girza.
(Address) 313 S. Madeira St

15 Filed , 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 " 1921.

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1921, to July 1, 1921, that I last saw her alive on July 1, 1921, and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Valentine, M. D.

, 19 (Address) 1324 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem.	July 5 " 1921
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann

JUL 2-1921 Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55048

D 55048

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 N Ellwood ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Townsend

(a) RESIDENCE. NO. 114 N Ellwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Townsend

6 DATE OF BIRTH (month, day, and year) January 28 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath

PARENTS

10 NAME OF FATHER William Metzgar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. Townsend (Address) 114 N Ellwood

15 Filed JUL 2 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 19

17 I HEREBY CERTIFY, That I attended deceased from June 30 19 21, to June 30 19 21,

that I last saw h[illegible] alive on June 30 19 21,

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G. Clemm M. D.

19 (Address) Fayette Bet Potomac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	July 3 1921
20 UNDERTAKER	ADDRESS
Wendell Dippel & Son	378 Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55049 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55049

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 Parrish ST.: 15 WARD)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilson McNeil

(a) RESIDENCE. NO. 1440 Parrish ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Negro	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) not known

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
45		~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore D 74

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer ~

9 BIRTHPLACE (city or town) Cheraw
(State or country) South Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ~
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ~
(State or country) South Carolina

14 Informant P. Brown
(Address) 1440 Parrish St

15 Filed Robert P. Harrison, Registrar
6-2-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1921, to June 30, 1921, that I last saw him alive on June 23, 1921, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease.

(duration) 1 yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John E. N. Camper, M. D.

, 19 (Address) 1405 N. Mount.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 1921
Cheraw South Carolina	
20 UNDERTAKER James H. Dennis (Cheraw S.C.)	ADDRESS 1363 Druid Hill Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 55050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55050

CERTIFICATE OF DEATH.

154

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 313 E Lanvale ST., 17 WARD)

2-FULL NAME Anna Sapp.

(a) RESIDENCE NO. 313 E Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zeda Ann Sapp

6 DATE OF BIRTH (month, day, and year) Sept 3 1822

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	98	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER William Sapp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Albert H. Sapp (Address) 3006 W Eutaw

Filed JY 2 1921 Robert P. Harrison, Registrar

Dr Brouwer. Preventive Dental.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from June 24th, 1921, to July 2nd, 1921, that I last saw him alive on July 1st, 1921 and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Senility. (Age 99 in Sept 1921)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Ulmer Brinton, M. D.

, 19 (Address) N.W. Cor Calvert & Preston Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore. DATE OF BURIAL July 7 1921

20 UNDERTAKER Wm Cook ADDRESS 502 E Eutaw

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55051 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55051

CERTIFICATE OF DEATH. X 41

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. St. Joseph's Hospital ST.: 9 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Lusby.

(a) RESIDENCE. NO. Manakin Lancaster Co. Va WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

If married, widowed, or divorced
HUSBAND of (or) WIFE of Don't know

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 28.				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10 NAME OF FATHER James Liggett
11 BIRTHPLACE OF FATHER (city or town) (State or country) Va
12 MAIDEN NAME OF MOTHER Sarah Yeatman
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Jimmy Lusby Va.
(Address) Baltimore

Filed JUL 2 1921, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1921, to July 1, 1921, that I last saw h.r alive on July 1, 1921 and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of breast

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 28, 21

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) S. W. Kinney, M. D.

19 (Address) 623 N. Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Monastican Wharf Va DATE OF BURIAL July 3 1921

20 UNDERTAKER William Cook ADDRESS 522 E. Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 55052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55052

CERTIFICATE OF DEATH

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Cabash Ave (Street) Roland Park (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte L Raessmann

(a) RESIDENCE NO. Cabash Ave (Street) Roland Park (Ward) 27th

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): May 25 1852

7 AGE — Years: 69 — Months: 1 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): 168

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Christopher Raessmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Beta Lange

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Emma L. Bischoff, Cabash Ave Roland Park

15 Filed ..... 19..... Robert F. Harrison, Registrar

L 2 7 1921

Carlos 422 Roland Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1921, to July 1, 1921, that I last saw h[illegible] alive on July 1, 1921, and that death occurred, on the date stated above, at 3-45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

3 hours

(duration)

CONTRIBUTORY (Secondary): Arterio Sclerosis (duration) 12 + yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hard arterio tension.

(Signed) M. H. Poole, M. D.

7/1, 1921 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 4 1921

20 UNDERTAKER: Wm Cahoon & Bro — ADDRESS

mation should be carefully supplied. Age, number CAUSE OF DEATH in plain terms, so that a cert TION is very important. See instructions on back of certificate.

D 55053

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55053

CERTIFICATE OF DEATH.

1 9

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 213 N Arlington Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Page.

(Residence in Baltimore: No. 213 N Arlington Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, May (Month) 6 (Day), 1893 (Year)

7-AGE. 28 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoe Shiner
(b) General nature of industry, business, or establishment in which employed (or employer): Shoe Store

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Albert Page

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Gertrude Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gertrude Page
(Address) 225 Amity St

15-
Filed ....., 192.. Robert P. Harrison, Registrar.

2-1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 1 (Day), 1924 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Nephritis following
Ball Game x 9 Innings
(Duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Uraemia Convulsions
(Duration) ..... yrs. ..... mos. 1 hr. ds.

(Signed) James W Newton M. D.
(Coroner.)
July 1, 1924 (Address) 700 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, July 3 1924

20-UNDERTAKER Dink Taylor — ADDRESS 916 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55054

CERTIFICATE OF DEATH.

120 D 55054

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No 1621 Ashland av ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Feldman

(a) RESIDENCE. No. 1621 Ashland av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 40 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Aaron Feldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mahrer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

11 Informant Mrs Feldman

(Address) 1621 Ashland

15 Filed JUL 3 - 1921 19 ROBERT I. KRAUTZ Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1921, to June 30, 1921, that I last saw him alive on June 30, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis Chronic interstitial Nephritis type Fibrin

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Haemoplegia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) D.A. Michelson, M. D.

, 19 (Address) 1420 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebw Blair Rd.	July 3, 1921
20 UNDERTAKER	ADDRESS 1127 E
Wm Levinson	Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

177145
D 55055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 D 55055

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward M. Gross.

(a) RESIDENCE. NO. 114 W. 23rd St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15-21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		2 wks 2 da	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward H Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Carey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Johns Hopkins Hospital, Record

15 Filed JUL 3 - 1921 ROBERT F. CARTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 — 1921

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1921, to July 1st, 1921, that I last saw him alive on July 1st, 1921, and that death occurred, on the date stated above, at 7.30 p m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic disease of New Born

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) W Dawson, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 3 1921
20 UNDERTAKER Wm R A Elliott	ADDRESS 1725 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55056

D 55056

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4912 O'Donnell ST.: 760 WARD)

2-FULL NAME William Mullaney.

(a) RESIDENCE. NO. 4912 O'Donnell ST., 26 WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas P. Mullaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Dorothea Boyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Thomas P. Mullaney (Address) 4912 O'Donnell St.

15 Filed JUL 3 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1921, to July 2, 1921, that I last saw him alive on July 2, 1921, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

6 Months Toxemia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Jellow, M. D.

7/2, 1921 (Address) 38 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL July 3 1921

20 UNDERTAKER Lilly & Zuber ADDRESS 1038 W. Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 55057

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55057

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1749 Hanover ST. 23 WARD)

2-FULL NAME John H. Sadler

(a) RESIDENCE. No. 1749 Hanover ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline I Sadler

6 DATE OF BIRTH (month, day, and year) Oct 9 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furs Hide Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Sadler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Eliza Swift

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs. Caroline I. Sadler 1749 Caroline St.

15 Filed JUL 3 - 1921 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from June 26 1921, to July 2 1921, that I last saw h.. alive on July 2 1921, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Ephamberia.

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Campbell M. D.

(Address) 1649 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Baltimore Cem. July 5 1921

20 UNDERTAKER — ADDRESS

Wm Cook 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55058

CERTIFICATE OF DEATH.

172 D 55058

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Noah Simms

(Residence in Baltimore: No. 1427 E. Monument St. 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Sgl

6-DATE OF BIRTH, ... (Month) ..... (Day) 1878 (Year)

7-AGE, 43 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman.
(b) General nature of industry, business, or establishment in which employed (or employer): Tanner Co

9-BIRTHPLACE. (State or Country), S. Carolina

PARENTS.

10-NAME OF FATHER, Frank. Simms

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Ida Johnson

13-BIRTHPLACE OF MOTHER (State or Country), S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rich. Simms

(Address) 1427 E. Monument

15- Burial Permit Clerk

Filed JUL 3 - 1921 191 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 1 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract. Jaw bone (mandible) with sinusitis. V.O.

14 days (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Septaemia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

July 7, 1921. (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn cemetery

DATE OF BURIAL, July 3, 1921

20-UNDERTAKER R. C. Good

ADDRESS 1405 McElderry

P. S. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

55059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 55059

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3600 Greenmount Ave. Gulford WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James McCulloch Herring

(a) RESIDENCE. No. 3600 Greenmount Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 28 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) America Expr Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER David Herring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Jane McCready

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edward Herring

(Address) 3600 Greenmount Boulevard

15 Filed JUL 3 1921, 19.....

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1921

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to July 1, 1921,

that I last saw him alive on July 1, 1921,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uncertain (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of ——

Was there an autopsy? No Tests of urine

What test confirmed diagnosis?

(Signed) Edwin B. Fenby, M. D.

7-1-1921 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: July 4th 1921

20 UNDERTAKER: [illegible] Walker

ADDRESS: 723 N. Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55060

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55060

REGISTERED NO. X 20

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Brown

(a) RESIDENCE. NO. 3 Baldwin Ave, Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27-1921

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	/	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Cannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital, Peabody

15 Filed JUL 3 - 1921 Registrar

Burial permit issued

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Indefinite terms, such as "Heart Failure," "Kidney Trouble," "Pneumonia," "Tuberculosis," "Cancer," "Stroke," "Paralysis," "Old Age," "Infantile Debility," "Convulsions," "Childbirth," "Accident," "Fracture," "Burns," "Drowning," "Homicide," "Suicide," "Found Dead," "Sudden Death," "Coroner's Case," are not sufficient. If from accident, violence, or casualty, state how it occurred, whether accidental, suicidal, or homicidal. If from disease of an organ, state what caused it, if known. If from childbirth, state whether single or multiple, and whether before, during, or after labor. If from any of the diseases peculiar to women, state definitely what disease. If from any of the diseases peculiar to children, state definitely what disease. If from any of the diseases peculiar to infants, state definitely what disease. If from any of the diseases peculiar to old age, state definitely what disease. If from any of the diseases peculiar to males, state definitely what disease. If from any of the diseases peculiar to females

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.: Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably had a septicaemia. Source of infection unknown.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55061

D 55061

CERTIFICATE OF DEATH.

45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 N. Charles ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Woodis Goldsborough

(a) RESIDENCE. NO. 1003 N Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Lee Goldsborough

6 DATE OF BIRTH (month, day, and year) Sept 21st 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va.

PARENTS

10 NAME OF FATHER Hunter Woodis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Louise Reardon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Capt N. L. Goldsborough (Address) 1003 N Charles St

15 Filed JUL 3 1921 Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. State whether disease, injury, accident or suicide. Write plainly and use ink. Fill all blanks. Make no abbreviations or use ditto marks. Be sure to answer every question. Do not return this certificate to undertaker. Do not bury body until certificate is filed with Registrar of_certificates. INFORMATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1921, to July 2, 1921, that I last saw h-- alive on June 30, 1921, and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Pleura

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic examination of blood from patient by injection

(Signed) Charles O'Donovan, M. D.

(Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 5 1921
20 UNDERTAKER	ADDRESS
Henry H Jenkins & Sons Co	Richard & McCollough

D 55062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55062

CERTIFICATE OF DEATH.

45 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1805 Lemmon ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert F. Taubenheim

(Residence in Baltimore: No. 1805 Lemmon St.; Yrs., 38 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Marr

6-DATE OF BIRTH, Jan (Month) 17 (Day), 1851 (Year)

7-AGE, 70 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): Dro Shops

9-BIRTHPLACE, (State or Country) Germany

PARENTS.

10-NAME OF FATHER, — Taubenheim

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline Taubenheim

(Address) 1805 Lemmon St

15- JUL 3 - 1921 Filed ....., 191.... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer of throat, Dr. Howard Kelly may be able to give correct Diag.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lack of Nourishment & Difficulty Swallowing on account of

(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

July 1, 1921 (Address) 740 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, July 4, 1921

20-UNDERTAKER Harry H Wirth

ADDRESS 1531 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Brooks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55063

CERTIFICATE OF DEATH.

28 V

REGISTERED No. C D 55063

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 625 n Bedford St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Brooks

Residence in Baltimore: No. 625 n Bedford St.; (yrs. 16 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, Col—

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) S

6-DATE OF BIRTH, May 10, 1905
(Month) (Day) (Year)

7-AGE, 16 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jas Brooks

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mamie Hawkins

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Brooks

(Address) 625 N Bedford

15-

Filed JUL 3 - 1921 ROBERT S. KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Wm. Imlay M. D.
(Coroner)

1-3 1921 (Address) 4 E Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Laurel Cemetery — DATE OF BURIAL, July 5 1921

20-UNDERTAKER Walter Davis — ADDRESS 413 N Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55064

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55064

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH Mt Winans

CITY OF BALTIMORE: (No. 1321 Annapolis Av ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Nathaniel Eckels

(a) RESIDENCE. No. 1321 Annapolis Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Eckels

6 DATE OF BIRTH (month, day, and year): May 21 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer): Nat Biscuit

(c) Name of employer: Stamping Co

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Nathaniel Eckels

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER: Lyde Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Emma Eckels (Address) 1321 Annapolis Av

15 Filed JUL 3 - 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/1 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/29/17, 19 , to 7/1, 1921, that I last saw h[illegible] alive on 7/6/30, 1921, and that death occurred, on the date stated above, at 6.22 A. m.

The CAUSE OF DEATH* was as follows:

5431 Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) Philip S. Fowler, M. D.

7/1, 1921 (Address) 1482 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	7/4/21

20 UNDERTAKER: W. J. Desmond Sons ADDRESS: Natl Bank Bldg

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

55065 D 55065

HEALTH DEPARTMENT—CITY OF BALTIMORE

55065 157 D 55065

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 604 S. Clement St. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Peak.

(a) RESIDENCE. No. 604 S. Clement ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days | If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Chas A. Peak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Dorothy Meyer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Chas A. Peak 604 S. Clement

15 JUL 4 - 1921 ROBERT J. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1921, to July 2, 1921, that I last saw h[illegible] alive on July 2 1921 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yr. mos. 1 ds.

CONTRIBUTORY (Secondary): Premature birth about 7 mos. wt 2 1/2 lbs

(duration) yr. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D.

7-3-21 (Address) 682 Columbus Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Cemetery

DATE OF BURIAL: July 4 1921

20 UNDERTAKER: Geo Lemlein & Son

ADDRESS: 580 W Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

M 9937 55066 B 55066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 177 55066

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H Smith

(a) RESIDENCE. No. 207 21st Ave ST., WARD. Nashville Tenn

(Usual place of abode) Nashville Tenn

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Smith

6 DATE OF BIRTH (month, day, and year) Oct 4 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 93H

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10 NAME OF FATHER Jas. H. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Elizabeth Polk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant (Address) Johns Hopkins Hospital Baltimore

15 Filed JUL 4 - 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 — 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11 — 1921, to July 3 — 1921, that I last saw h[illegible] alive on July 3 — 1921, and that death occurred, on the date stated above, at 2:50 p. m.

The CAUSE OF DEATH* was as follows:

Bilateral Pyelonephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Septicemia (colon)

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? Nashville Tenn

Did an operation precede death? Yes Date of June 20 21

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Herman A. Gailey, M. D.

. 19 (Address) Johns Hopkins Hos

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nashville Tenn	July 3 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

55067 D 55067

HEALTH DEPARTMENT—CITY OF BALTIMORE

55067 D 55067

CERTIFICATE OF DEATH.

55-001

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene Sts. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floyd Henderson

(a) RESIDENCE. NO. Grafton. W. Va ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dessie E. Henderson

6 DATE OF BIRTH (month, day, and year) Feb 21, 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34			

8 OCCUPATION OF DECEASED 073

(a) Trade, profession or particular kind of work Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer) B&O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER John D Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Taylor Co. W. Va

12 MAIDEN NAME OF MOTHER Polly Rudy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant (Address) Commodore Henderson Grafton W. Va

15 Filed JUL 4 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 1921 to July 3 1921

that I last saw h / Malive on July 3 1921

and that death occurred, on the date stated above, at 11½ A. m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary) Brain Tumor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Grafton. W. Va

Did an operation precede death? NO Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical signs

(Signed) H. B. Jones, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grafton W. Va

DATE OF BURIAL 7/4/21 19

20 UNDERTAKER Harry H Witzke

ADDRESS 1531 W. Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55068

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D 55068

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1421 E. Hoffman St. 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winfield Williams

(Residence in Baltimore: No. 1421 E. Hoffman St. 22 yrs. 9 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH Sept 4, 1898 (Month) (Day) (Year)

7-AGE 22 yrs. 9 mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Machinist 1031
(b) General nature of industry, business, or establishment in which employed (or employer) John S Stragler

9-BIRTHPLACE (State or country) Baltimore

PARENTS

10-NAME OF FATHER David Williams

11-BIRTHPLACE OF FATHER (State or country) Harford Co Md

12-MAIDEN NAME OF MOTHER Lilly Ghalk

13-BIRTHPLACE OF MOTHER (State or country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lilly Williams

(Address) 1421 E. Hoffman

15-Filed JUL 4 - 1921 ROBERT J. BRUTER Deputy Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 3, 1921 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Jun 2, 1921, to July 2 1921.

that I saw h[illegible] alive on July 2, 1921.

and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Abt one year (Duration) ---- ds

Contributory (SECONDARY) (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. K. Johns M. D.

July 3, 1921 (Address) 1107 N Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 6 1921

20-UNDERTAKER Henry Lutz

ADDRESS 1007 N. Bond St

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55069

CERTIFICATE OF DEATH.

151 D 55069

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1843 N. Duncan ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R. Moulden

(Residence in Baltimore: No. 1843 N. Duncan St.; — yrs., 1 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 3 (Day), 1921 (Year)

7-AGE,	If LESS than 1 day,
— yrs. 1 mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Chas. A. Moulden

11-BIRTHPLACE OF FATHER (State or Country), D. C.

12-MAIDEN NAME OF MOTHER Elizabeth Plock

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilbur H. Davison
Elizabeth Moulden.

(Address) 1843 N. Duncan St.

15-

Filed JUL 4 1921 191.....

ROBERT L. KRAUTH
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 25 1921, to July 1 1921, that I saw h[im] alive on July 1 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus
Prematurity

(Duration)— yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wilbur H. Davison M. D.

July 3, 1921 (Address) 1843 N. Duncan St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. July 4, 1921

20-UNDERTAKER Henry Lutz

ADDRESS 1007 N. Bond

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55070

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 55070

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 322 N Streeker ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Johnson

(a) RESIDENCE. No. 322 N Streeker ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col'd	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer Essex C Va

9 BIRTHPLACE (city or town) (State or country) Essex Co Va

PARENTS

10 NAME OF FATHER Solom Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co Va

12 MAIDEN NAME OF MOTHER Dina Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Emporia

14 Informant H. H. Lee
Address 322 N Streeker St

15 JUL 4 - 1921 ROBERT J. BRAUTIGAM Registrar
Burial records clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1921, to July 1, 1921, that I last saw h alive on June 30, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulm Tbc

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F Norwood, M. D.

July 1 1921 (Address) 937 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 4 1921
20 UNDERTAKER Brown & Freeland	ADDRESS 1140 W Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55071

HEALTH DEPARTMENT—CITY OF BALTIMORE

40

D 55071

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4505 Pennhurst St.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaux Anna Randle

(Residence in Baltimore: No. 4505 Pennhurst Ave St.: ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Nov 6, 1852
(Month) (Day) (Year)

7-AGE, 68 yrs. 8 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Abraham Winters

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Amanda Evans.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Randle

(Address) 4505 Pennhurst

15- JUL 4 - 1921 Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 8th 1921, to July 2 1921, that I saw h[er] alive on July 1 1921, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
Stomach and intestines

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Nichols M. D.

7-2-1, 1921. (Address) Pikesville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge Cem

DATE OF BURIAL, July 4, 1921

20-UNDERTAKER Joseph B. Cole

ADDRESS 1003 W. Balto St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE (Roddy) ✓

D 55072

D 55072

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2419 Guilford ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Roddy.

(a) RESIDENCE. NO. 2419 Guilford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widowed

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Thos J. Roddy

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Owen Finnian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Hanora Scott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Jennie Harman. (Address) 2419 Guilford Ave

15 Filed JUL 4 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1917, to July 2 1921.

that I last saw her alive on July 2 1921.

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

diabetes

(duration) 4 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Benj. D. Hayden M. D.

7/3. 1921 (Address) 1216 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvert Cem

DATE OF BURIAL: 7/5/21 19

20 UNDERTAKER: Chas Ecarnot Son

ADDRESS: 118 W. Mt Royal ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

32 D 55073

CERTIFICATE OF DEATH.

D 55073

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ~~St.~~ 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Chankiewicz

(a) RESIDENCE. No. 122 S. Wolfe St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
Male	White	Single

5a If married, wtdowed, or divoreed
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Paul Chankiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records.
(Address) New City Hospitals.

15 Filed JUL 4 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1921, to July 2, 1921, that I last saw him alive on July 1, 1921, and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Spine - Dorsal
Tuberculosis of the Hip - Left.

(duration) 1 yrs. 3 mos. ds.

* CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? P

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) E. P. Bradrup, M. D.

7/2/1921 (Address) New City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL 7/4 1921

20 UNDERTAKER Wm Jackson — ADDRESS Wolfe

D 55074

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 55074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3736 - Mt. Pleasant St.: No WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Concetta Cavallaro

(Residence in Baltimore: No. 3736 - Mt. Pleasant St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	W	Single

6-DATE OF BIRTH, June (Month) 1 (Day) 1899 (Year)

7-AGE,	If LESS than 1 day,
21 yrs. 1 mos. 1 ds.	~~hrs. or~~ ~~min.~~

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None - 000
(b) General nature of industry, business, or establishment in which employed (or employer) at Home

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Cavallaro

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Maria D'Angelo

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Cavallaro

(Address) 3736 - Mt Pleasant St

15- Filed JUL 4 - 1921 ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Stan Mitchell M. D. (Coroner.)

July 1, 1921 (Address) 1600 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Sacred Heart Cem.	7/4/21 19....

20-UNDERTAKER Geo. J. Ruth ADDRESS 1728 Hanford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55075

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55075

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1604- N. Spring ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laudus F. Waldhauptes

(a) RESIDENCE. No. 1604- N. Spring ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 2/10/1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. Waldhauptes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Huber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm. Waldhauptes (Address) 1604- N. Spring St

15 Filed JUL 4 - 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1921, to July 2, 1921, that I last saw h.e. alive on July 2, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Marasmus

fever

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Ignanition

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 1604 N Spring

Did an operation precede death? ..... Date of

Was there an autopsy? no

What test confirmed diagnosis? Emaciation

(Signed) J F Carman, M. D.

7-4-1921 (Address) 1701 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	7/5/21

20 UNDERTAKER Geo J Ruth ADDRESS 1735 Hanford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No gastro enteritis.
Further
No history. Phy.
only attended 1 day.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55076

CERTIFICATE OF DEATH.

D 55076

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 E. Hoffman ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William O. Benny

(Residence in Baltimore: No. 1231 E. Hoffman St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-WHETHER SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. February (Month) 9 (Day), 1835 (Year)

7-AGE. 86 yrs. 4 mos. 13 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Shoe Dealer

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John Benny

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Caroline Hall

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosetta Benny

(Address) 1231 E. Hoffman St.

15- Filed JUL 4 - 1921, 191.... Registrar.

CAUSE OF DEATH in plain terms so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 21 1921, to July 2 1921, that I saw h im alive on July 1 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Esophagus

(Duration) yrs. 5 mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) Hubert Eskridge M. D.

July 3, 1921 (Address) 1216 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cemetery

DATE OF BURIAL. July 4, 1921

20-UNDERTAKER. H. E. Hughes

ADDRESS 824 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 55077

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1055 Harford Ave. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Breuning

(a) RESIDENCE. No. 1055 Harford Ave. ST., 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 0 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of the late Marcus Breuning

6 DATE OF BIRTH (month, day, and year) June 29-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Rosemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Roth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna C Breuning
(Address) 1055 Harford Ave

15 FILED JUL 4 - 1921 ROBERT J KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1921, to July 3, 1921.

that I last saw her alive on July 2, 1921.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure - Edema / Lungs / myocarditis - Enteritis - Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William F. Schwarz, M. D.

7/3, 1921 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery.	July-6- 19 21

20 UNDERTAKER Henry Horch & Son ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55078

CERTIFICATE OF DEATH.

66 D 55078

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 E. Biddle. St.) ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard. J. Hubbell

(a) RESIDENCE. NO. 909 E. Biddle St. ST., 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced: HUSBAND of the late Anna.M. Hubbell (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 15 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired deputy warden

(b) General nature of industry, business, or establishment in which employed (or employer): 686

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: M. B. Hubbell
(Address): 909 E Biddle St

15 Filed JUL 4 - 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-3-1921

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to July 3, 1921, that I last saw h-e alive on July 3, 1921, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteri-Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? While at work

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Kinlow, M. D.

74. 1921 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 6 1921
20 UNDERTAKER: Henry Hoech & Son	ADDRESS: 1301 E Eager

INFORMATION should be carefully supplied. Avoid abbreviations. Write plainly. Be sure to have CAUSE OF DEATH properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No haemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

Laszczuk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55079

CERTIFICATE OF DEATH.

8-091 D 55079

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 S Durham ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Laszczuk

(a) RESIDENCE. No. 210 S. Durham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Laszczuk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Laszczuk. (Address) 210 S. Durham St

15 Filed JUL 4 - 1921 ROBERT F. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to July 3, 1921, that I last saw h alive on July 3, 1921, and that death occurred, on the date stated above, at 3 00 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis, Bronchopneumonia & Toxic Enteritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Heart failure & exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & symptoms

(Signed) Jos. A Duffy M. D.

. 19 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL July 4" 1921.

20 UNDERTAKER W. F. Sadowski, ADDRESS 708 S. Ann

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 55080

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55080

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 S. Charles ST. 23 WARD)

2-FULL NAME Charles J. Duckett

(a) RESIDENCE. NO. 1807 S. Charles ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Duckett

6 DATE OF BIRTH (month, day, and year) Oct 14-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Ice house

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John K. Duckett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ellen Feeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Dora Duckett

(Address) 1807 S. Charles st.

Filed JUL 4 - 1921 M. J. KRAUTH Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2/21 19

17 I HEREBY CERTIFY, That I attended deceased from 7/2/21, 19 .., to 7/2/21, 19 ,

that I last saw h... alive on 7/2/21, 19 ,

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis, Rt. side - Hemiplegia ovr 1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Sclerosis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert L. Ley M.D.

7/2/21 (Address) 120 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	July 5th 1921
20 UNDERTAKER	ADDRESS
F. A. Krauser & son	703 Hanover

mation should be carefully supplied. Any [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

1921
47
1894

1920
46
1894

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of Baltimore (No. Mercy Hospital St. 2nd Ward) 186

Registered No. C D 55081

2-FULL NAME Austin F. Creighton

(Residence in Baltimore: No. 601 S. Hanover.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, October (Month) 3 (Day) 1871 (Year)

7-AGE.	If LESS than 1 day, ...hrs. or.....min.?
49 yrs. 9 mos. ds.	

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shipfitter
(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter

9-BIRTHPLACE, (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER, William Creighton

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Susan Travis

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. H. Creighton

(Address) 601 S. Hanover st

15- Filed JUL 4 - 1921 191 M. A. KRAUTH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 3 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures accident

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) J. C. Blades M. D.
(Coroner)

July 3 1921 (Address) 1436 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loth End Cem. Middlesex Co. Va.	July 5 1921

20-UNDERTAKER	ADDRESS
J. A. Krauser Son	703 Hanover st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55082

CERTIFICATE OF DEATH.

1821 D 55082

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John B. Johnson

(Residence in Baltimore: No. 431 N Gilmor St.; yrs. 26 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, Aug. 2, 1894 (Month) (Day) (Year)

7-AGE, 26 yrs. 10 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Jobbing for himself

9-BIRTHPLACE, (State or Country), Balto. md.

PARENTS.

10-NAME OF FATHER, Calvin Johnson

11-BIRTHPLACE OF FATHER (State or Country), Balto Co.

12-MAIDEN NAME OF MOTHER Mary Humphries

13-BIRTHPLACE OF MOTHER (State or Country), Charles Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Johnson

(Address) 431 N Gilmor St

15-

Filed JUL 4 - 1921 BY E KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound through Lg. Pelvis cutting bowels & several places. Homicide

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Hemorrhage

Acute (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) James M Fenton M. D. (Coroner.)

July 2, 1921 (Address) 100 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 400 Block N Bond St

Former or usual residence 431 N Gilmor St.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, 6/4/21, 19....

20-UNDERTAKER Samuel W Chase-son

ADDRESS 1400 Hoffman st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55083

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Provident Hospital 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME India Frances Handy

(Residence in Baltimore: No. 2027 Mc Culloh St.; 50 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, (Month) (Day) 1865 (Year)

7-AGE, 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): 237

9-BIRTHPLACE, (State or Country), Westmoreland Co Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Tolson

(Address) 2027 Mc Culloch St

15- JUL 4 - 1921 Filed, 191. ROBERT S. BRUTER Registrar. Clerk

Cause of death to be plainly written, and all items answered if possible. Omissions will delay burial certificate. Information required by law is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 2 (Day), 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from June 1 1921 to July 1 1921, that I saw h[illegible] alive on July 1 1921, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Malaria Fever

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

July 3, 1921 (Address) 1413 D. Hilton

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State 56 yrs. mos. ds.

Where was disease contracted, if not at place of death? 2027 Mc Culloh St

Former or usual residence 2027 Mc Culloh St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, 7, 5, 1921

20-UNDERTAKER J Leon Hall — ADDRESS 1741 D H [illegible]

Apoplectic.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55084

D 55084

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH Baltimore, Md

CITY OF BALTIMORE: (No. 430 N. Carey ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schneider

(a) RESIDENCE. No. 430 N. Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Adam Schneider

6 DATE OF BIRTH (month, day, and year) 15/Feb. 1830

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ford G. Mettel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Winifred Brenton

(Address) 430 N. Carey St.

15 Filed JUL 4 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/July 1921

17 I HEREBY CERTIFY, That I attended deceased from October, 1920, to 2/July, 1921, that I lost saw h[illegible] alive on 2/July, 1921 and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 9 yrs. 9 mos. 17 ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Carlus L. Baggott, M. D.

, 19 (Address) 1207 Mosher St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Potter's Field	July 4 1921
20 UNDERTAKER	ADDRESS
A Rohdenburg	600 Park Ave

Spec.--1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55085

CERTIFICATE OF DEATH.

64 D 55085

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Gorsuch Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Nickles

(a) RESIDENCE NO. 510 Gorsuch Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Nickles

6 DATE OF BIRTH (month, day, and year) Dec 5 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	57			

8 OCCUPATION OF DECEASED 614

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Chas M. Stieff

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto-

PARENTS

10 NAME OF FATHER Augustus Nickles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret Nickles

(Address) 510 Gorsuch Ave

15 Filed JUL 4 - 1921 ROBERT P KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1921, to July 3, 1921, that I last saw h[illegible] alive on July 3, 1921, and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Henry C. Alger M. D.

(Address) 3645 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL July 6 1921

20 UNDERTAKER Wareham Cook — ADDRESS Fort Ave

IMPORTANT: Write carefully in ink. Exact statement of occupation may be necessary. Do not use abbreviations. Be sure that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Arterio Sclerosis - Renal
Cerebral Hemorrhage -
Progressive (until complete)
left side Para plegia
Pulmonary Oedema

Spec.—6-9-19—H. P. Co.—1000 Bks.

May Kiess

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55086

CERTIFICATE OF DEATH.

X 14

D 55086

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Howard & Kelly Hospital (St.) 14 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs H. A. Kiess

(a) RESIDENCE. No. 1418 Eutaw Place St., Ward. Mt Washington Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry A Kiess

6 DATE OF BIRTH (month, day, and year): March 12 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40.	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: J. H. Messinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Mary L. Reichard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa. Penna

14 Informant: Mrs. H. A. Kiess (Address) 100 Park Ave. City

15 Filed JUL 4 – 1921 ROBERT J. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1921, to July 3, 1921, that I last saw h[illegible] alive on July 3, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure following Cholecystotomy with removal of gall stone (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 28 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dudley A Robnett, M. D.

. 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lork. Pa.

DATE OF BURIAL: July 4 1921

20 UNDERTAKER: Chenoweth Son

ADDRESS: Chestnut Pa

CAUSE OF DEATH and PLACE OF BURIAL must be stated. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55087

CERTIFICATE OF DEATH.

104 D 55087

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 443 W 26th St. Ward 12)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Johnson

(a) RESIDENCE. NO. 443 W 26th St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: [illegible]

6 DATE OF BIRTH (month, day, and year): May 24 1921

7 AGE: Years [illegible] Months 1 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer: [illegible]

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Geo. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Ash

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: George Johnson

(Address) 443 W 26th St

15 Filed JUL 4 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/28 1921 to 7/3 1921

that I last saw her alive on 7/3 1921

and that death occurred, on the date stated above, at 1.25 a. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration) [illegible] yrs. 1 mos. [illegible] ds.

CONTRIBUTORY (Secondary): Anasarca

(duration) [illegible] yrs. [illegible] mos. [illegible] ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of [illegible]

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) J Cyril Bo[illegible], M. D.

, 19 (Address) 25-31 Mahoden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden

DATE OF BURIAL: July 4 1921

20 UNDERTAKER: Chenowith & Son

ADDRESS: Edmondson Ave

N. B.—Information should be carefully supplied. AGE should be given in every case, as it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec —8-24-14—M. & T.—2000 Bks.

D 55088

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55088

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 918 Druid Hill Av ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward R. Blake

(Residence in Baltimore: No. 918 Druid Hill Av St.; — yrs., 5 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Color	Single

6-DATE OF BIRTH. January 8th, 1921. (Month) (Day) (Year)

7-AGE. — yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... ———

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Samuel R. Blake

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Lizzie Butler

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie E. Blake

(Address) 918 Druid Hill Av.

15- JUL 5 — 1921 191.... G. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 3d, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 30th 1921, to July 3 1921, that I saw h im alive on June 30th 1921, and that death occurred, on the date stated above, at 3 30/60 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis (Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Cerebral Concussion

..... (Duration) ... yrs. ... mos. 1 ds.

(Signed) Edward L. Kartmann M. D.

July 4, 1921. (Address) 1224 W. Mosher Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem — DATE OF BURIAL. July 5, 1921.

20-UNDERTAKER Daniel Easton — ADDRESS 916 Pa Ave

CAUSE OF DEATH must be stated in plain English. Do not use abbreviations or initials. Do not state mode of dying, such as heart failure, asthenia, etc., but the disease or injury which caused death. Additional important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55089 — 31 — D 55089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (St.) (Ward) 24th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Cole

(a) RESIDENCE. No. 609 Greenwillow St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Bl	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Feby 1 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. W. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Fannie Hicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Mrs. Annie Hill 576 St Marys Street

15 Filed JUL 5 - 1921 . 19 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2nd 1921, to July 3rd 1921, that I last saw h[illegible] alive on July 3rd 1921, and that death occurred, on the date stated above, at 7.18 p m.

The CAUSE OF DEATH* was as follows:

Probably Tuberculous pneumonia

(duration) 1 yrs. 6 mos. 3 ds.

CONTRIBUTORY (Secondary) Anemia and Tympanites

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. [illegible] Med. Dept. M. D.

. 19 (Address) Bay View Asylum, Md. Dept

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn Cem July 6 1921

20 UNDERTAKER — ADDRESS

Hamb Hunsley Middle 578

CAUSE OF DEATH must be plainly written, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55090 HEALTH DEPARTMENT—CITY OF BALTIMORE 15/V D 55090

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1148 Carrollton Ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Stall

(Residence in Baltimore: No. 1148 Carrollton Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Color

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 3d, 1921 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 3 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), 1148 Carrollton Ave

PARENTS.

10-NAME OF FATHER. Earl Stall

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Amelia Corbett

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Stall

(Address) 1148 Carrollton Ave

15-

Filed JUL 5 — 1921 G. H. Gro... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 3d, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3d 1921, to July 3d 1921, that I saw h[illegible] alive on July 3d 1921, and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows: Premature birth

7 months gestation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) A. Lee Ellis M. D.

7/3, 1921, (Address) 27 Mad Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL, July 5 1921

20-UNDERTAKER Saml T. Hemsley ADDRESS 518 N. Bond St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55091

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 55091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1307 Eastern Ave ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Diacont

(a) RESIDENCE. No. 1307 Eastern Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Diacont

6 DATE OF BIRTH (month, day, and year) Dec. 18, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Kaspar Goetze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Mamie Howard 3111 Montebello Ave

JUL 5 - 1921

G. H. Gress, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1921, to July 4, 1921,

that I last saw her alive on July 3, 1921

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral - Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral - Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John F. Owens M. D.

19 (Address) Fairmount Ave + Potomac

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL July 7 1921

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Reed

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

D 55092 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital St.; Ward)

2-FULL NAME Rudolph Borman.

(Residence in Baltimore: No. Monument Road. St.; yrs., mos. ds.)

REGISTERED No. C 7775-00

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Baby

6-DATE OF BIRTH, April (Month) 14 (Day), 1918 (Year)

7-AGE, 3 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Rudolph Borman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Frieda Wink

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frieda Borman

(Address) Colgate

15-

JUL 5 1921. 191.... G. H. Gress Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Legs

Gangrene (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)

7-5-, 191.. (Address) 4 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem. DATE OF BURIAL, July 6, 192

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Pleasant St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. M. Co.—1000 Bks.

D 55093 D 55093 D 55093

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 122 f Marshall ST. 73 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Henry Fontz

(a) RESIDENCE NO. 122 f Marshall ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 10 mos. 23 ds. How long in U. S., if of foreign birth? 82 yrs. 10 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) 9, 20 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82	9	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab O & C

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jacob Fontz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Forrester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. C. Fontz

(Address) 1224 Marshall

15 Filed ..... 19.. JUL 5 - 1921 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7.3 1921

17 I HEREBY CERTIFY, That I attended deceased from 6.6 1921, to 7.3 1921, that I last saw him alive on 7.3 1921, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valv Heart Dis

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. J. Burlington M. D.

, 19 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	7/6 1921
20 UNDERTAKER	ADDRESS
I Frew Mc Cully	130 E Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement must be complete. Do not use abbreviations or terms not generally understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55094

CERTIFICATE OF DEATH.

B 55094

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1338 Whetcroft ST.; 15 WARD)

REGISTERED No. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Hayden

(a) RESIDENCE. No. 1338 Whetcroft ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 26-1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co. Md.

PARENTS

10 NAME OF FATHER Clement Hayden

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co. Md

12 MAIDEN NAME OF MOTHER Rebecca Hensley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co. Md

14 Informant (Address) Mrs Rebecca Hensley St Marys Co. Md

15 Filed JUL 5 - 1921 G. H. Cress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1921, to July 3, 1921, that I last saw h[illegible] alive on July 3, 1921, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Asthenia (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Nothing

(Signed) Paul Brokaw M. D.

July 3. 1921 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Spences Mill St Mary Co Md	July 6 1921
20 UNDERTAKER	ADDRESS
Edward R Maggold	1463 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55095

CERTIFICATE OF DEATH.

107 D 55095

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 103 W. Hughes ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Tazwell

(a) RESIDENCE. NO. 103 W. Hughes ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 19, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew Tazwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Newport News Va.

12 MAIDEN NAME OF MOTHER Alice Chinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Andrew Tazwell
(Address) 103 W. Hughes St

15 JUL 5 - 1921 C. M. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20th 1921, to July 2nd 1921.

that I last saw her alive on July 2nd 1921.

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D. T. Tazwell M. D.

7/5, 1921 (Address) 1401 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn Ct — July 5. 1921

20 UNDERTAKER — ADDRESS

J. H. Brown & Son 1108 W. Monty

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55096

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170

D 55096

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 Lemmon Lake Restaurant Lake side or WARD) 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Papa

(a) RESIDENCE. No. 220 Glenmore Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent Papa.

6 DATE OF BIRTH (month, day, and year) Nov. 10. 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50.	8.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Nicholas De Vito

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary De Rosa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant M. J. E. Dippel

(Address) 37 E. Eager St

15 Filed JUL 5 1921 G. H. Gregg Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1921, to July 4, 1921, that I last saw h alive on July 03, 1921, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Coma Uremia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Bright's disease with Peripheral Neuritis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urine analysis

(Signed) D. F. Morrison M. D.

. 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cemetery	July 7. 1921
20 UNDERTAKER	ADDRESS
Wendell Dippel & Son	37 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55097

CERTIFICATE OF DEATH.

170

D 55097

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 S Wolfe ST.: 7 WARD)

2-FULL NAME Matilda Schutt.

(a) RESIDENCE. NO. 316 S Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed of John Schutt

6 DATE OF BIRTH (month, day, and year) Jan 20 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
72	5	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Francis Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Jno Schutt (Address) 316 S Wolfe St

15 Filed JUL 5 - 1921 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1917, to July 2, 1921, that I last saw h. alive on July 2, 1921 and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Leo Keller M. D.

(Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 5 1921
20 UNDERTAKER	ADDRESS
Millard B Callender	5 Saint Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55098 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55098

CERTIFICATE OF DEATH. 145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Callender

(a) RESIDENCE. NO. 432 N. Kenwood Ave ST., City WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. Life ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23 - 21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			7 wks.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Jesse J. Callander

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Callander

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Johns Hopkins Hospital
(Address) Records

15 Filed JUL 5 - 1921 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1921, to July 7, 1921, that I last saw h. alive on July 7, 1921, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Impetigo (bullous)

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Horton Casparis M. D.

7-7-21 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	July 8th. 1921
20 UNDERTAKER	ADDRESS
Millard B Callender	Same St

CAUSE OF DEATH must be plainly written. Avoid use of abbreviations. Physicians are requested to fill in certificates. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

55099 — 1921 — 55099

REGISTERED No. C

1. PLACE OF DEATH
CITY OF BALTIMORE (No. 14 N Calhoun ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME David L. Kennedy

(Residence in Baltimore: No. 14 N Calhoun St. (yrs. 13 mos. dz.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Married

6-DATE OF BIRTH, Oct (Month) 13 (Day), 1847 (Year)

7-AGE. 73 yrs. 8 mos. 21 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman 66
(b) General nature of industry, business, or establishment in which employed (or employer): Fred Mackey

9-BIRTHPLACE (State or Country). Kentucky

PARENTS.

10-NAME OF FATHER. Wm Kennedy

11-BIRTHPLACE OF FATHER (State or Country). Kentucky

12-MAIDEN NAME OF MOTHER Elizabeth Price

13-BIRTHPLACE OF MOTHER (State or Country). Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Francis T. Kennedy
(Address) 14 N Calhoun St

15- FILED JUL 5 1921, 191 G. H. Grese Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 2 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Organic Valvular disease of Heart

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(Duration) [illegible] yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

July 2. 1921 (Address) 700 Chas St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19-PLACE OF BURIAL, OR REMOVAL. Mt Olivet Cemetery — DATE OF BURIAL, July 5, 1921

20-UNDERTAKER Joseph B Cook — ADDRESS 1003 W. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55100

CERTIFICATE OF DEATH.

115

D 55100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Hugh. Mc. Neill

(a) RESIDENCE. NO. 2513 Dulany St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
~~Male~~	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12"1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36 yr.	-	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pvt. Sanitary Det

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer for City of Baltimore, Md.

(c) Name of employer Balto. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER ~~Thomas~~ Mc Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Farrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Mary A. Mc Neill
(Address) 2513 Dulany St.

15 Filed ..... 19 ..... G. H. Grace Registrar

JUL 5 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17

I HEREBY CERTIFY, That I attended deceased from June 18, 1921, to 7/4, 1921, that I last saw him alive on 7/4/21, 19..., and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Thrombophlebitis of Portal Vein & Mesenteric Veins
Hepatic Abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

7/4, 1921 (Signed) Dudley P. Bowe, M. D.

(Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 7 1921
20 UNDERTAKER	ADDRESS
Jos B Cook	1003 N Balto

CAUSE OF DEATH. Write plainly in ink. Do not use abbreviations. Your certificate is incomplete unless it is signed. Read carefully the instructions on back of certificates. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55101

CERTIFICATE OF DEATH.

×37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Franklin Hospital 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Wagner

(a) RESIDENCE. NO. Bengies Rd ST., WARD. Bengies Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leo L. Wagner

6 DATE OF BIRTH (month, day, and year) March 13/76

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	45	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Masik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Josepha Kodelka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Leo L. Wagner

(Address) Bengies Md

15 Filed JUL 5 - 1921 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/4/ 1921

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1921, to July 4, 1921, that I last saw h She alive on July 4, 1921, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Lobar Pneumonia (duration) 1 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Int Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & Symptoms.

(Signed) Hugh A. Brent, M. D.

, 19 (Address) 16 E. Chase St—

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	July 6 1921
20 UNDERTAKER	ADDRESS
H. C. Windefeld	Greenmount Av

CAUSE OF DEATH in plain terms. No abbreviations may be used. Any additional information may be given on back of certificates.
TION is very important. See instructions on back.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lucia

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 30

D 55102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Carter

(a) RESIDENCE. NO. 1437 Wolfe St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ~~6~~ 2 months ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Virginia
(State or country) lie in Baltimore 2 months

PARENTS

10 NAME OF FATHER Charlie Carter

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Jannie Coles

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUL 5 - 1921 G. H. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1921, to July 4, 1921, that I last saw her alive on July 4, 1921, and that death occurred, on the date stated above, at 9 39 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY —
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Lumbar puncture.

(Signed) Horton Casparis, M. D.

7-4-21, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 5 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Eutaw St

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 55103

CERTIFICATE OF DEATH.

120 D 55103

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Frederick Ave ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha L Vogell

(Residence in Baltimore: No. 1635 Frederick Ave St.; 70 yrs., 3 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March (Month) 9 (Day), 1851 (Year)

7-AGE, 70 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Charles Vogell

11-BIRTHPLACE OF FATHER (State or Country), Hanover Germany

12-MAIDEN NAME OF MOTHER Louise Kesmodel

13-BIRTHPLACE OF MOTHER (State or Country), Ehrfurt Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie L. Mehlgarten

(Address) 2517 Maryland Ave

15- G. H. Grese.

Filed JUL 5 1921, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1921, to July 1 1921, that I saw h[illegible] alive on July 1 1921, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hepatitis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis

(Duration) 2 yrs. mos. 7 ds.

(Signed) Chas Memorial M. D.

7/2/21, 191... (Address) 24 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park. DATE OF BURIAL, July 5, 1921.

20-UNDERTAKER Harry R Thwaites ADDRESS 4204 Redgewood Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55104

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

120 D 55104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 264 S: Highland Ave ST.: 26 WARD)

2-FULL NAME Harry I: Little

(a) RESIDENCE. No. 264 S: Highland Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lydia A: Little

6 DATE OF BIRTH (month, day, and year) Jan 12th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheelright

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

007

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Isriel Little

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Margaret Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) Mrs Lydia A: Little 264 S: Highland Ave

15 Filed JUL 5 - 1921 BOYLE ? FRANKLIN Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations not to be used. Diseases peculiar to women must be described. Deaths from accident, violence, or suicide must be fully explained. Deaths from contagious diseases must be reported immediately by telephone. Physicians are required to report to the Health Department the existence of every case of disease dangerous to life coming under their observation. Failure to report is punishable by fine. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 12 . 1921 . to July 4 . 1921.

that I last saw him alive on July 3 . 1921.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) unknown ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) G. J. France, M. D.

, 19 (Address) 2939 W. Eldorado St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Seven Stars Md.	7/7/1921
20 UNDERTAKER John Herwig & co	ADDRESS 2008 Erlen

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55105

D 55105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St.; 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marmon Jones

(Residence in Baltimore: No. 1109 Mc Culloh St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 17 (Day), 1914 (Year)

7-AGE, 6 yrs. 11 mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Saulsbury Md

PARENTS.

10-NAME OF FATHER, Wm Jones

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Fannie Bartlett

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Jones

(Address) 1109 Mc Culloh St

15- Filed JUL 5 - 1921 191 ROBERT I. KRAUTH Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 22 1921, to July 4 1921, that I saw him alive on July 4 1921, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Hypostasis

(Duration) yrs. mos. 7 ds.

(Signed) E. E. Hughes M. D.

July 5, 1921 (Address) 1430 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 12 ds. In the State 7 yrs. mos. ds.

Where was disease contracted, if not at place of death? at residence

Former or usual residence 1109 Mc Culloh St

19-PLACE OF BURIAL OR REMOVAL, Saulsbury Md — DATE OF BURIAL, July 28, 1921

20-UNDERTAKER Saml Bloxsom & Son — ADDRESS Westminster

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55106

D 55106

CERTIFICATE OF DEATH.

48

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Tudor Hall - (Roland Park) 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Morris Ridgely

(a) RESIDENCE. NO. Tudor Hall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred all life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Horace Ridgely

6 DATE OF BIRTH (month, day, and year) Nov. 16th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Wesley A. Tucker

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca J. Trimp

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mary T. McGinn

(Address) Anderson Park. Md.

Filed JUL 5 - 1927 ROBERT A. KRAUSE Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 1913, to July 4, 1921, that I last saw h[illegible] alive on July 4, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic infectious arthritis

(arthritis deformans)

(Bedsores Hands for 5 years)

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bedsore. Septicaemia

(duration) [redacted] yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Staphylococcus from joint

(Signed) Harold. Smith, M. D.

, 19 (Address) 927 S. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hampton Estate - Balto Co	7-6 1921
20 UNDERTAKER	ADDRESS
Henry Jenkins Sons Co	McCulloh Orchard.

CAUSE OF DEATH. [illegible] on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55107

CERTIFICATE OF DEATH.

79

REGISTERED NO.

D 55107

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1020 Madison Ave. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Morris Conkling

(a) RESIDENCE. NO. 1020 Madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 7, 1826

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	94	7 mos.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER William H. Conkling

11 BIRTHPLACE OF FATHER (city or town) Connecticut
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Sibson

13 BIRTHPLACE OF MOTHER (city or town) Scotland
(State or country)

14 Informant Miss Josephine Conkling
(Address) 1020 Madison Ave

15 Filed JUL 5 - 1921 19

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1921, to July 3, 1921, that I last saw h.. alive on July 3, 1921, and that death occurred, on the date stated above, at 11:30 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocardial - fatty (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Joseph W. Kelly, M. D.

, 19 (Address) 2327 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 6th 1921
20 UNDERTAKER Henry H. Jenkins Sons Co	ADDRESS McCulloh & Orchard Sts.

CAUTION is very important. See instructions on back of certificates.

X-Callahan

D 55108

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1554 N. Fulton Av ST. 15 WARD)

2-FULL NAME Gilbert Edward Kelly

(a) RESIDENCE. NO. 1554 N. Fulton Av ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lester O'Mara

6 DATE OF BIRTH (month, day, and year) Feb 22/1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Bartholmew Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Harding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John X Kelly

(Address) 1554 N. Fulton Av

15 JUL 5 - 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10 . 1921. to July 2 . 1921.

that I last saw him alive on July 2 . 1921.

and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 27 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward H Callahan M. D.

7/5/21 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	July 1921

20 UNDERTAKER Martin Fahey & Sons ADDRESS 7 W Monte

CAUSE OF DEATH must be stated plainly, so that a correct classification may be made. See instructions on back of certificate. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55109

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 55109

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St. Vincents Infant Asylum ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Herbert Bowen

(a) RESIDENCE. NO. 1401 Division ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant St. Vincent Inf. Asylum
(Address) 1401 Division St.

15 Filed ..... 19.....

JUL 5 - 1921

ROBERT I. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1921, to July 1st, 1921, that I last saw him alive on July 1st, 1921, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas A Clemens M. D.

(Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudenbeal — DATE OF BURIAL: July 5 1921

20 UNDERTAKER: Martin Fahey Dom. — ADDRESS: 1527 N. Howard Baltimore

CAUSE OF DEATH must be stated plainly. See that all questions are answered. Use ink. Write plainly. Do not abbreviate. Use no ditto marks. Make no erasures. Be sure to answer every question. Where none, or not known, write "None" or "Unknown." Do not write in margins or between lines. Fill in all blanks. Be particular to give number of house in all cases. Write with pen and ink. Do not use pencil. Sign certificate. Do not fail to fill out and sign the certificate on back of certificates. See instructions on back of certificates. THIS is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55110

HEALTH DEPARTMENT—CITY OF BALTIMORE

8/ D 55110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 Madison av ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Rachel Wilmer Torbert

(Residence in Baltimore: No. 1520 Madison av St.; ..... yrs., 1 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH. April 7, 1839 (Month) (Day) (Year)

7-AGE, 82 yrs. 3 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Edwin Wilmer

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Hannah Elyza McCready

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wilmer

(Address) 1520 Madison Av

15- Filed JUL 5 - 1921 ROBERT I. KRAUTER Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 4, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1921, to July 4 1921, that I saw her alive on July 4 1921, and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion

(Duration) ..... yrs. ..... mos. 3 hours

CONTRIBUTORY (Secondary) Carbuncle of Abdomen

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Joseph E. Sudler M. D.

July 5, 1921 (Address) 1526 Madison Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Edlon Md

DATE OF BURIAL. July 7, 1921

20-UNDERTAKER Wallace Curtis

ADDRESS 502 E North

Spec.—6-9-19—H. P. Co.—1000 Pks.

D 55111

HEALTH DEPARTMENT—CITY OF BALTIMORE

55111

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 Philadelphia Road near Bowleys Lane ST.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Langenfelder.

(a) RESIDENCE. No. Philadelphia Road near ST.. Bowleys Lane WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Langenfelder.

6 DATE OF BIRTH (month, day, and year) March 16th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Maryland

PARENTS

10 NAME OF FATHER Henry Buck

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Germany

14 Informant (Address) John Langenfelder Bowleys Rd.

15 Filed JUL 5 1921 [illegible] Registrar

Burial [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17

I HEREBY CERTIFY, That I attended deceased from June 30 1921. to July 4. 1921.

that I last saw h[illegible] alive on July 3 1921.

and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

~~Uremic~~ [illegible]

Apoplexy

(Duration) hr. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed ~~diagnosis~~? Microscopic

(Signed) Barry Long, M. D.

July 4. 1921 (Address) 27 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Lutheran Cemetery	July 6 '21

20 UNDERTAKER Fredk Lucas & Son ADDRESS Fullerton

CAUSE OF DEATH ... TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 ✓ D 55112

1-PLACE OF DEATH ~~D~~ 55112

REGISTERED NO.

CITY OF BALTIMORE: (No. 826 Raborg ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Coleman

a) RESIDENCE. No. 826 Raborg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1 1921

7 AGE	Years	Months	Days

If LESS than 1 day 16 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Cornish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Alice Ruth Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Alice Ruth Coleman
(Address) 826 Raborg St

15 JUL 5 - 1921 ROBERT F. KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1921

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1921, to July 1, 1921, that I last saw h(im) alive on July 1, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Prematurity
1 28 wks. factor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harris Reese, M. D.

(Address) 7-7, 1921 University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

14427 D 55113

CERTIFICATE OF DEATH.

76 D 55113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benem Dare

(a) RESIDENCE. NO. 1805 Presbury St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benem Dare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Emma Holiberton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUL 5 - 1921 ROBERT I. GRAHAM Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1921, to June 25, 1921, that I last saw h alive on June 25, 1921, and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH* was as follows:

Tetany

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Electrical Reaction

(Signed) W. C. Davison, M. D.

6-28-21 19 (Address) JHH

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL JUL 5 1921 Commissioner Health

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55114

CERTIFICATE OF DEATH.

152 ✓

D 55114

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gibson

(a) RESIDENCE. NO. 254b Mace ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 19 hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Raymond Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Viola Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant R. Riddall (Address) Johns Hopkins Hospital

15 Filed JUL 5 1921 ROBERT J. BRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1921, to June 30, 1921, that I last saw him alive on June 30, 1921, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Intra-cranial Hemorrhage

Forceps Delivery

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) John W. Harris, M. D.

7/1, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER Commissioner Health

ADDRESS JUL 1921

CAUSE OF DEATH must be plainly stated, and all questions answered. See instructions on back of certificates.

Spec.—6-2-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55115

CERTIFICATE OF DEATH.

X 28 D 55115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St.. 26 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Stephens

(a) RESIDENCE. No. Non-resident ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Frank Stephens

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lizzie Bruton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records (Address) M.T.H.

15 Filed JUL 5 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1921

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to June 28, 1921, that I last saw h... alive on June 28, 1921, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous periostitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) [illegible] M. D.

6-28-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health.

JUL 5 1921

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55116

170 ✓ D 55116

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 709 Harford Ave St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Jackson

(a) RESIDENCE. No. 709 Harford Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Jackson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(h) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not known

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs R. Nixon
(Address) 704 N. Harford Ave.

15 Filed JUL 5 - 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 1921 to July 5 1921
that I last saw h~~is~~ alive on July 3 1921
and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) / yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✱

Was there an autopsy? No

What test confirmed diagnosis? ✱

(Signed) J. E. Thomas M. D.

7-5. 1921 (Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information required in back of certificates. See instructions on back of certificates. TION is very important.

UNIVERSITY OF MARYLAND
Commissioner Health.
Mar. Wm. R. WOODALL

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55117

D 55117

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1109 Fulton ST.: 21 WARD)

2-FULL NAME Mack McKinley

(a) RESIDENCE. NO. 1109 Russell St ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

087

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

11 Informant

(Address)

15 Filed ..... 19 ..... Registrar

JUL 5 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1921, to July 2, 1921, that I last saw ... alive on July 2, 1921, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) arterio Sclerosis

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dean, M. D.

, 19 (Address) 1227 Columbia St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	JUL 5 1921
20 UNDERTAKER	ADDRESS
Commissioner Health.	

TION is very important. See instructions on back of certificates.

Spec.--6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55118 ✓ 28 D 55118

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse J. White

(a) RESIDENCE. NO. 1004 Readenhall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Lab

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): East St. Louis. Missouri

PARENTS

10 NAME OF FATHER Nathan White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Missouri

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Missouri

14 Informant P. J. Sweeney
(Address) Warden's Md. Penitentiary

15 Filed JUL 5 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-29 1921

17 I HEREBY CERTIFY, That I attended deceased from April-3, 1921, to June-29, 1921, that I last saw him alive on June-29, 1921, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis and Exhaustion

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 2 mos. 26 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination & Exhaustion

(Signed) William G. Schwartz, M. D.

6/30, 1921 (Address) Md. Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 1921

20 UNDERTAKER Commissioner Health.

ADDRESS

By Wm. F. Woodall

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF MODE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55119 CERTIFICATE OF DEATH. 37 D 55119

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Florence Bailey.

(a) RESIDENCE. No. Pantego, N. C. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 42 Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed JUL 5 1921. ROBERT J. KRAFFT Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1921

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to June 29, 1921, that I last saw h.. alive on June 29, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

1. Myxedema

2. Syphilis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) Dudley P. Bowen, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER	ADDRESS
Commissioner Health.	JUL 5 1921

Pat. Wm. E. WOODALL

CAUSE OF DEATH. Physicians are required to fill out the statements on this certificate, supplying the items of information called for as fully and accurately as possible, and are urged to make every effort to obtain the information required from relatives or friends. The value of the certificate depends upon its completeness and accuracy. See instructions on back of certificates. TION is very important.

THE MORGUE

D 55120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172 D 55120

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1410 Webster St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia C. DeMinnis.

(Residence in Baltimore: No. 1410 Webster St.

St.: 75 yrs., 6 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Widow.

6-DATE OF BIRTH, December 18th. 1845, 1 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
75 yrs. 6 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John H. Warns.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Mary Weinkamp.

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. DeMinnis. (son)

(Address) 1410 Webster St.

15- JUL 5 - 1921 Filed ..... Registrar.

CAUSE OF DEATH in plain terms, and as many of the following items as may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 3rd. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of the brain and shock.
due to accidental fall down stairs.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

July 5th 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Augustine Cem. DATE OF BURIAL, July 6., 1921

20-UNDERTAKER Margaret V. Flynn ADDRESS 1412 Light St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55121

CERTIFICATE OF DEATH.

28 D 55121

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3447 (Street) Roland Ave (ST.:) 13 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond G. Kopp

(a) RESIDENCE. No. 3447 Roland Ave. ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 5 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 26-1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Geo. H. Kopp

11 BIRTHPLACE OF FATHER (city or town) (State or country): York Co. Pa.

12 MAIDEN NAME OF MOTHER: Annie M. Fuhrman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): York Co. Pa.

14 Informant: Mrs. Annie M. Kopp.
(Address): 3447 Roland Ave.

15 JUL 5 - 1921 ROBERT J. BRAUTIGAM Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3. 1921

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to July 3, 1921.

that I last saw him alive on July 3 1921.

and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Antecedents (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical + examination

(Signed) W. H. Smith, M. D.

1921 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	July 6 1921

20 UNDERTAKER	ADDRESS
Horace H. Burgee	3631 Falls Rd

CAUSE OF DEATH. Items must be filled in by the attending physician. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55122

CERTIFICATE OF DEATH.

284 D 55122

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2036 Hollins ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Lynch

(a) RESIDENCE. NO. 2036 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Worker

(b) General nature of Industry, business, or establishment in which employed (or employer): Structural

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget McHugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Mary Lynch (Address) 2036 Hollins St

15 Filed JUL 5 - 1921 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1921, to July 2nd 1921, that I last saw him alive on July 1st 1921, and that death occurred, on the date stated above, at 5-45 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

7/5/21 (Address) 846 W 36th St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 7/6/21 19

20 UNDERTAKER: George C Ivey Fulton & Fayette — ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55123

CERTIFICATE OF DEATH.

151 D 55123

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2610 Riggs Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Dubois Davis

(a) RESIDENCE. NO. 2610 Riggs ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 18 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER William H. Davis

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mrs Elsie L. Davis

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mrs. E. L. Davis
(Address) 2610 Riggs Ave

15 Filed JUL 8-1921 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 5 1921.

That I last saw he alive on July 3 1921.

and that death occurred, on the date stated above, at 5 40 P m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Improper feeding

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard S. Grant M. D.

, 19 (Address) 707 Mummasburg

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL July 6th 1921

20 UNDERTAKER ROBERT BROOKS & SON

ADDRESS Calhoun & Pulliam

FUNERAL DIRECTORS & EMBALMERS

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55124

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 55124

1-PLACE OF DEATH Womens Hospital

CITY OF BALTIMORE: (No. ..... ST.: 29 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Groome Anderson

(Residence in Baltimore: No. 304 Dudley Ave St.: 33 yrs., ? mos., ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Unknown (Month), ... (Day), 1859 (Year)

7-AGE.	If LESS than 1 day,
62 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): " " 037

9-BIRTHPLACE, (State or Country). Pennsylvania

PARENTS.

10-NAME OF FATHER. Thomas Groome

11-BIRTHPLACE OF FATHER (State or Country). Pennsylvania

12-MAIDEN NAME OF MOTHER Rachael Eppley

13-BIRTHPLACE OF MOTHER (State or Country). Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman E. Tannenbaum

(Address) Womans Hospital.

15-

Filed JUL 6 1921 191. G. H. Gross Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July (Month) 5 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 2 1921, to July 5 1921, that I saw her alive on July 4 1921, and that death occurred, on the date stated above, at 12.25 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Hyp. Russian

(Duration) 3+ yrs. ..... mos. ..... ds.

(Signed) Herman E. Tannenbaum M. D.

July 5, 1921. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State 33 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 304 Dudley Ave

19-PLACE OF BURIAL OR REMOVAL. Woodwardville-AA Co. Md DATE OF BURIAL. July 7 1921

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOOBER, Supt.) ADDRESS 108 W. NORTH AVE.

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55125

CERTIFICATE OF DEATH.

D 55125

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 209 S Castle ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Jacob Haase

(a) RESIDENCE. No. 209 S Castle ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elisabeth Haase

6 DATE OF BIRTH (month, day, and year) Oct. 7 - 1840

7 AGE 80 Years 8 Months 27. Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailores

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer Radecker. Sons

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Johann H Haase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany -

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant William E Haase
(Address) 209 S Castle.

15 Filed JUL 6 1921, 19 ... Registrar

G. H. Grese.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1921, to July 4, 1921, that I last saw him alive on July 4, 1921, and that death occurred, on the date stated above, at 8 50 p m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene S. Pearre M. D.

July 6, 1921, 19 (Address) 2314 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuels Cemetary	July 7, 1921
20 UNDERTAKER	ADDRESS
Louis Heemann.	32 S Broadway

TION is very important. See instructions on back of certificates.

male. 6-9-19—H. P. Co.—1000 Bks.

D 55126 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55126

CERTIFICATE OF DEATH. X 173

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mike Koon.

(a) RESIDENCE. No. Glen Lee, W. Va. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 9 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Mike Koon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungaria

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungaria

14 Informant Hospital Record
(Address) Mercy Hospital

15 Filed JUL 6 1921 Registrar G. H. Grese

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 22 1921, to July 1 1921, that I last saw h(im) alive on July 1 1921, and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Glen Lee W. Va.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Erwin M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cem	7/6/21
20 UNDERTAKER Geo A Farley Sulton	ADDRESS 4 Fayette

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fall of slate in mine.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55127

CERTIFICATE OF DEATH.

105

REGISTERED NO. D 55127

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1125 Sterrett St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline E Ebert

(a) RESIDENCE. NO. 1125 Sterrett ST., 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of D S Ebert

6 DATE OF BIRTH (month, day, and year) Apr. 21, 1847

7 AGE Years 74 Months 2 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant C Ebert (Address) 1125 Sterrett

15 Filed JUL 8-1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2 19 21 to July 4 19 21

that I last saw alive on July 3 19 21

and that death occurred, on the date stated above, at 6:15 P.M.

The CAUSE OF DEATH* was as follows:

Exaustion

Ileo Colitis 7 15

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. M. D. Ellis Emmart M.D.

, 19 (Address) 1120 W Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL July 6 1921

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55128 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55128

50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2007 West Pratt ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry E. Musgrove

(a) RESIDENCE. No. 2007 West Pratt ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Musgrove

6 DATE OF BIRTH (month, day, and year) Dec. 4" 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bristle Comber

(b) General natore of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer Dell Brush Co

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Musgrove

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Heddrick

13 BIRTHPLACE OF MOTHER (city or town) Balto? Co.

(State or country) Maryland

14 Informant Mrs. Anna E. Musgrove

(Address) 2007 West Pratt St.

15 JUL 6 1921 G. H. Creed Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4" 1921

17

I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 4 1921, that I last saw him alive on July 4 1921, and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Diabetis Coma

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H W Jones, M. D.

(Address) Dr. Covington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 6 1921

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N Calvert

CAUSE OF DEATH must be plainly written, and must state the disease which caused death, or which caused the accident or violence which produced death. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55129 D 55129

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hollins Ferry Road and Annapolis Ave. Mt. Winans St.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elisha H. Hines

(Residence in Baltimore: No. 92 Bruce Rd. St.: 71 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1 (Year)

7-AGE, Abt. 61 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) C & O

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Mr. Hines

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. F. Bristol

(Address) Mt. Winans

15- Filed JUL 6-1921, 191.....

G. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2 1921, to July 5 1921, that I saw him alive on July 3 1921, and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation 1 day

(Duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. 3 ..... ds.

(Signed) Jos. F. Bristol M. D.

July 6, 1921. (Address) 109 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill Cem

DATE OF BURIAL, July 8, 1921

20-UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Balto St.

Important. See instructions on back of certificate.

Myocarditis Chr. No other abnormal condition.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Grese

—6-9-19—H. P. Co.—1000 Bks.

D 55130

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55130

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 941 N. Patterson Pk. ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walburga Roth

(a) RESIDENCE. No. 941 N. Patterson Pk ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Roth

6 DATE OF BIRTH (month, day, and year) March 19/1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ger.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Mrs. Fannie Baxter (Address) 941 N. Patterson Pk. ave

15 Filed JUL 6 - 1921, 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17

I HEREBY CERTIFY, That I attended deceased from July, 19 21, to July 5, 1921, that I last saw her alive on July 5, 1921, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH was as follows:

Cardiac Dysentery and Exhaustion

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Benj. D. Hayden, M. D.

July 6, 1921 (Address) 1216 N. Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 8 1921

20 UNDERTAKER Leo F. Kerr ADDRESS 15 E. Lanvale

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 55131

CERTIFICATE OF DEATH

D 55131

179

1. PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No annapolis ave 1st mun ST. 25 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Mabel B Stanley

(Residence in Baltimore: No. annapolis ave St.; 1 yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: C

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: oct 20, 1920 (Month) (Day) (Year)

7. AGE: yrs. 9 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9. BIRTHPLACE (State or country): Md

PARENTS

10. NAME OF FATHER: Thos Stanley

11. BIRTHPLACE OF FATHER (State or country): Md

12. MAIDEN NAME OF MOTHER: Clara Harris

13. BIRTHPLACE OF MOTHER (State or country): Md

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Stanley

(Address) annapolis ave 1st Mun

15. Filed JUL 6 1921, 191 G. H. Grese REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 4 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4, 1921 to July 4 1921 that I saw h-er alive on July 4, 1921. and that death occurred, on the date stated above, at 5.10 P m. The CAUSE OF DEATH* was as follows:

Heat Stroke

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Thos B Hall M. D.

(Address) Holliday St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 7/6, 1921

20. UNDERTAKER: Jas Scott Hoge — ADDRESS: 406 W. Lexington St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55132 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55132

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl F. Kolsa

(a) RESIDENCE. NO. 1431 N. Central Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 17 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of J. P. Kolsa

6 DATE OF BIRTH (month, day, and year) aug 5th 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER W Haslep

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Pearl Onie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Josh P. Kolsa
(Address) 1720 Harford ave

Filed July 6 1921 G. H. Gresa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1921, to July 4, 1921, that I last saw her alive on July 4, 1921, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(duration) Unknown yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

, 19 (Address) 11 Johns Hop

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Swarz Cemetery	July 6 1921

20 UNDERTAKER Young & Ruth ADDRESS 1735 Harford ave.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55133

D 55133

150

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1560 Carswell ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Granville Muir

(a) RESIDENCE. No. 1560 Carswell ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 600

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Daniel C. Muir

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary E. Majors

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City Md.

14 Informant Daniel C. Muir
(Address) 1560 Carswell St.

15 Filed JUL 6 1921 L. E. Wood Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17

I HEREBY CERTIFY, That I attended deceased from July 3 1921 to July 5 1921,

that I last saw him alive on July 5 1921,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Geo. L. Zimmerman M. D.

, 19 (Address) 928 N Hanford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	July 6 1921

20 UNDERTAKER Wm. C. Black ADDRESS 927 N Broadway

CAUSES OF DEATH in plain terms, so that a non-medical person may understand. See instructions on back of certificates.
TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Case

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55134

CERTIFICATE OF DEATH.

119 D 55134

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1034 Edmondson Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Dobner

(Residence in Baltimore: No. 1034 Edmondson Ave St.; 41 yrs. 6 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
41 yrs. 6 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Louis F. Dobner

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Catherine A. Dietz

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis F. Dobner

(Address) 1034 Edmondson Ave.

15-

Filed....., 191.....

JUL 6 1921

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 6 1921, that I saw her alive on July 6 1921, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

(a) Uraemia

(b)

(c)

(Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Lobar pneumonia

(Duration) .....yrs. .....mos. 6 ds.

(Signed) M Bourn and Lord M. D.

July 6, 1921 (Address) 626 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, ~~OR REMOVAL~~,	DATE OF BURIAL,
Loraine	July 8, 1921
20-UNDERTAKER	ADDRESS
Geo W Little	2700 Edmondson Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bollman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55135

CERTIFICATE OF DEATH.

154 D 55135

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 703 N. Carrollton Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick M Bollman

(a) RESIDENCE. No. 703 N Carrollton Ave ST.

(Usual place of abode) WARD.

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Sept 18, 1838

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pittsburgh Pa

PARENTS

10 NAME OF FATHER: Charles M. Bollman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliza Clever

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Howard Schubert (Address) 703 N Carrollton Ave

JUL 6 1921 19

L. E. Wahn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5th 1921.

17 I HEREBY CERTIFY, That I attended deceased from May, 1921, to July 5th, 1921, that I last saw him alive on July 5th, 1921, and that death occurred, on the date stated above, at 4.0 m.

The CAUSE OF DEATH* was as follows: Cardiac Asthma & General Debility incident to age

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Howard Schubert M. D.

7/6, 1921 (Address) 703 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 7 1921

20 UNDERTAKER: Geo W Little ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH must be plainly written. Signature of attending physician is required. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55136

CERTIFICATE OF DEATH.

104 D 55136

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 Hoisguiff ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William G. Johnson

(a) RESIDENCE. NO. 1222 Hoisguiff ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 11 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George C. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Laughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs. Nellie Weyhaught
(Address) No. 2707 Hoffman Ave

15 Filed JUL 6 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5 1921, to July 5 1921, that I last saw him alive on July 5 1921, and that death occurred, on the date stated above, at 7 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Heat Stroke

(duration) hrs. yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hes Colitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirm diagnosis? None - Clinical

(Signed) Dr. J. Kinzer, M. D.

7-6, 1921 (Address) 2700 Hanford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 6 1921

20 UNDERTAKER Henry Hauck & Son ADDRESS 1301 E. Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-55137

79 D 55137

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3414 Seneca ST., 13 WARD)

2-FULL NAME Mary R Boone

(a) RESIDENCE NO. 3414 Seneca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Boone

6 DATE OF BIRTH (month, day, and year): March 6 1851

7 AGE: 70 Years | 5 Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Charles Bowersox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): John W Boone 3414 Seneca St

15 Filed JUL 6-1921 19 R. E. Webb Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1917 to July 4, 1921, that I last saw h[illegible] alive on July 4, 1921 and that death occurred, on the date stated above, at 10.30 p m.

The CAUSE OF DEATH* was as follows:

Goiter Decompensating.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Typical signs

(Signed) C. F. Templeton, M. D.

7-5, 1921 (Address) 570 Dolphin Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 7 1921

20 UNDERTAKER: Chenowith Son — ADDRESS: Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH statement must be filled in. See instructions on back of certificates. TION is very important.

Spec.—6-19—H. P. Co.—1000 Bks.

Cross 47816

D 55138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55138

CERTIFICATE OF DEATH.

45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. O'Connor

(a) RESIDENCE. No. 2507 Roslyn Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) OHS

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Henrietta Gaines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUL 6-1921, 19 R. R. Wells Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1921. to July 5, 1921.

that I last saw h[illegible] alive on July 5, 1921,

and that death occurred, on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder

Pyelitis

B. Coli septicaemia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-14-21

Was there an autopsy? Yes

What test confirmed diagnosis? Operative findings

(Signed) H H Bailey, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL July 8 1921

20 UNDERTAKER George J Smith

ADDRESS [illegible] N. Fayette

CAUSE OF DEATH in plain terms. Indefinite statements, such as "Heart Failure," "Asthenia," "Old Age," "Senility," "Uremia," "Convulsions," "Cancer," "Tumor," are insufficient. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55139

CERTIFICATE OF DEATH.

31 D 55139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Hewlett

(a) RESIDENCE. NO. 1523 Madison Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Major Hewlett

6 DATE OF BIRTH (month, day, and year): Oct 26 1896

7 AGE: 24 Years 8 Months 8 Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer): Cook

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina Lived in Baltimore 9 months

PARENTS

10 NAME OF FATHER: Arthur Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Martha —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed JUL 6 1921 19.. L. E. Wohlt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17 1921, to July 3 1921, that I last saw he alive on July 3 1921, and that death occurred, on the data stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

I. B. Pulmonary tuberculosis

(duration) yrs. 3-4? mos. ds.

CONTRIBUTORY (Secondary): Tub- genito ulcers

(duration) yrs. ½? mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes. Date of May 1921

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) Karl H. Nordhoff, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lexington Station N.C.

DATE OF BURIAL: July 6 1921

20 UNDERTAKER: Mrs Robert A Elliott

ADDRESS 1725- Eshbord Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 55140 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55140

G.H. Grace

CERTIFICATE OF DEATH.

91

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 442 St. Mary's ST. 11 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph White

(Residence in Baltimore: No. 442 St. Mary's St.: yrs., 3 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	Single

6-DATE OF BIRTH, March 12, 1921
(Month) (Day) (Year)

7-AGE, yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Joseph Wells

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER Addie White

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Addie White
(Address) 442 St. Mary's St.

15-
Filed ....., 191.... Registrar.

CAUSE OF DEATH to print plainly, as much as may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) yrs. 3 mos. 23 ds.

CONTRIBUTORY (Secondary) and history

(Duration) yrs. mos. ds.

(Signed) J. J. O'Hennessy M. D.
(Coroner)
July 6, 1921 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, July 4, 1921

20-UNDERTAKER Wm R A Elliott ADDRESS 1725 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55141

D 55141

CERTIFICATE OF DEATH.

79.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 222 Augusta Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albin Ed Jones

(a) RESIDENCE. NO. 222 Augusta Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Sarah Alice Jones

6 DATE OF BIRTH (month, day, and year) Jan. 11 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Eli Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant H W Jones (Address) 222 Aug Ave

15 Filed JUL 6 1921 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17 I HEREBY CERTIFY, That I attended deceased from January 19 19 to July 4th 19 21, that I last saw him alive on July 4th 19 21, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Elmer B Truman M. D.

19 (Address) 412 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 7th 19 21

20 UNDERTAKER F B Keppler ADDRESS 2336 Fred'k Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55142

D 55142

CERTIFICATE OF DEATH.

79

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Agnes Kaufman.

(Residence in Baltimore: No. 1536 E. 28th St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1856 (Year)

7-AGE,	If LESS than 1 day,
65 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Baltimore Co Md

PARENTS.

10-NAME OF FATHER John Kelly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles B. Kaufman

(Address) 524 W Lafayette St

15-

Filed JUL 6 1921 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 27 1921, to July 5 1921, that I saw her alive on July 5 1921; and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Old Age

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Herbert C. Blake M. D.

July 5, 1921 (Address) 1614 W Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park | DATE OF BURIAL, July 8th, 1921.

20-UNDERTAKER Martin Fahey & Sons | ADDRESS 827 W North Ave

Check off particulars as entry is made. Items of personal and statistical particulars are important. See instructions on back of certificate.

Size—6-9-19—H. P. Co.—1000 Blks.

D 55143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 55143

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 229 N Carlton ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Galloway

(a) RESIDENCE. No. 229 N Carlton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col'd	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Maria Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince Georges Md

14 Informant Wm Galloway

(Address) 229 N Carlton

15 Filed JUL 6 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1921, to July 3, 1921, that I last saw h alive on July 3, 1921, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Horwood, M. D.

(Address) 939 W Fayette St

July 7/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	July 7th 1921

20 UNDERTAKER A. Jones

ADDRESS 207 S Stricker St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Katherine V. Dudrow

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55144

CERTIFICATE OF DEATH.

167

D 55144

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 29 Josiah Harper St.; 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine V. Dudrow

(Residence in Baltimore: No. 1911 Greenmount Ave St.; yrs., 64-5-21 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Jan. 14, 1857
(Month) (Day) (Year)

7-AGE, 64 yrs. 5 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Donohue

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Rebecca M. Debow

13-BIRTHPLACE OF MOTHER (State or Country), Miss.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Gosden

(Address) 591 W. 178th St. N.Y.

15-Filed JUL 6- 1921, 191.... ROBERT P. KRAUTER Registrar.

Burial ... M. ...

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

Days (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. K. Ingalls M. D.
(Coroner)

7-6-, 191.., (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1911 Greenmount Ave

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, 7/7, 1921

20-UNDERTAKER Henry W. Weaver & Son

ADDRESS 5 & 5 N. CALVERT St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each answer important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55145

CERTIFICATE OF DEATH.

104

D 55145

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 22 WARD)

2-FULL NAME Samuel Markland

(a) RESIDENCE. No. 12 E. Montgomery St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Emma Markland (mother). 12 E. Montgomery St.

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Werden Markland.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma James.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital Records.

15 Filed JUL 6 1921 ROBERT J. BRAUNE Registrar

Burial Permit Oiven

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 - 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5 -, 1921, to July 6 -, 1921, that I last saw h.. alive on July 5 -, 1921, and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)
Acidosis

(duration) .. yrs. .. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) .. yrs. .. mos. .. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) W Davison M. D.

, 19 (Address) 717

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK. DATE OF BURIAL: JUL 7 1921

20 UNDERTAKER: JOHN F. DENNY ADDRESS: 715 LIGHT ST.

CAUSE OF DEATH must be filled in, signed, and returned to Registrar of certificates. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55146

CERTIFICATE OF DEATH.

45

D 55146

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1801 N. Gay ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles. H. Bell

(a) RESIDENCE. NO. 1801 N Gay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary A Bell

6 DATE OF BIRTH (month, day, and year) Sept 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meter Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Maryland Gas

(c) Name of employer Mcter Works Balto Md

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry T Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary E Ashcraft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary A Bell
(Address) 1801 N Gay st.

15 Filed JUL 6 - 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15 1921 to July 6 1921

that I last saw him alive on July 2 1921

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Sarcoma of left lung. (Apex region)

(duration) 8 mos.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) J. E. Bibbins M. D.

(Address) 1531 E. North Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
BALTIMORE CEMETARY	JUL 11 1921
20 UNDERTAKER JOHN F. DENNY 716	ADDRESS LIGHT ST.

TION is very important. See instructions on back of certificates.

D 55147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55147

CERTIFICATE OF DEATH.

A 64

4

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. W. A. B. Station ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augustus Watts. (Over)

(Residence in Baltimore: No. — — St.: yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Widower

6-DATE OF BIRTH.

....., 1 .....
(Month) (Day) (Year)

7-AGE. 72 about. yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), A. A. Co. Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W. McCubbin

(Address) 111 Dorchester

15- Filed JUL 6- 1921 191 ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 3 ....., 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Apoplexy death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) hrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) J. Ed. D. Ladies M. D.
(Coroner)

July 3 1921 (Address) 1131 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Friendship Cem	July ....., 1921
20-UNDERTAKER	ADDRESS
J. Frew McCully	130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

149193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55148

177 D 55148

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital (ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose. Pluschkell

(a) RESIDENCE. NO. 1422 Gough St. Boarding House ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb- 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work C Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Oscar Pluschkell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rose ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUL 6 - 1921 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1921, to July 5, 1921, that I last saw her alive on July 5, 1921, and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(traumatic)

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lumbar puncture

(Signed) W. B. Carson, M. D.

7-6-21, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patrick's	July 7 1921

20 UNDERTAKER E. P. Trussellbaug ADDRESS 2620 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 55149

CERTIFICATE OF DEATH.

28 D 55149

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1127 Hanticoke ST.: 21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Vorbringer

(a) RESIDENCE. NO. 1127 Hanticoke ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word)
Male	White	Widower

5a If married, widowed, ~~or divorced~~
~~HUSBAND~~ of
~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) June 19 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44		16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brass Molder
(b) General nature of industry, business, or establishment in which employed (or employer) 010
(c) Name of employer Baltic & Ohio

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER Paul Vorbringer
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Helen Gentz
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Helen Vorbringer 1117 Hanticoke st

15 Filed JUL 6 - 1921 ROYAL I. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/5/21 19

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to July 5, 1921,
that I last saw her alive on July 5, 1921,
and that death occurred, on the date stated above, at 10:30 p m.
The CAUSE OF DEATH* was as follows:

Tuberculosis 2 yrs.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs
(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Stephen A. Dowd, M. D.
, 19 (Address) 1027 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western cemetery	July 7, 1921
20 UNDERTAKER Robert Brookerson	ADDRESS Cor CALHOUN HOLLINS ST

CAUSE OF DEATH to be plain terms, so that a non-medical person may understand it. See instructions on back of certificates. TION is very important.

D 55150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55150

CERTIFICATE OF DEATH.

155

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Md. Gen. Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.)

2-FULL NAME Sarah E. Stonebreaker

(Residence in Baltimore: No. 527 W. 27th St.; 21 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED: (Write the word) Married

6-DATE OF BIRTH: July (Month) 19 (Day) 1900 (Year)

7-AGE: 20 yrs. 11 mos. 16 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wk House
(b) General nature of industry, business, or establishment in which employed (or employer): 837

9-BIRTHPLACE (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Albert E. Bell

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Charlotte Chalk

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm E. Stonebreaker

(Address) 527 W. 27th

15- Filed JUL 6-1921, 191... ROBERT J. KRAUSE Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) jury, find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Inhalation of Illuminating Gas

(Duration) ... yrs. ... mos. 15 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessy (Coroner) M. D.

July 6, 1921 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

527 W. 27th St.

Former or usual residence ... same ...

19-PLACE OF BURIAL OR REMOVAL: Mary's Garden — DATE OF BURIAL: July 8, 21

20-UNDERTAKER: William Cook — ADDRESS: 502 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55151

CERTIFICATE OF DEATH.

17 D 55151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St.: 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hutson

(a) RESIDENCE. NO. 953 N. Chapel ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word)
F	C	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Hutson

6 DATE OF BIRTH (month, day, and year) July 3, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook Ox 1

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Wm. J. Blankfard Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs. Marguerite Butler (Friend)

(Address) 903 Chapel St

15 Filed JUL 6 - 1921 ROBERT I. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/5 1921

17 I HEREBY CERTIFY, That I attended deceased from 7/2, 1921, to 7/5, 1921, that I last saw her alive on 7/4, 1921, and that death occurred, on the date stated above, at 12 10 A.m.

The CAUSE OF DEATH* was as follows:

Comminuted fracture of Hip (left) over

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 953 N Chapel St

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) R. J. Young M. D.

, 19 (Address) 1416 Jefferson St

*State the Disease Causing Death, or if death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 7/ 1921

20 UNDERTAKER Wm. Cook ADDRESS 502 E North Ave

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fell down steps at home
O. K'd
by J. T. Hennessy
Corner of N. Wilkins
2807 Edmondson Ave,

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55152

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55152

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hillsdale, Md. ST.: 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Ellsworth Parrish

(a) RESIDENCE. NO. 51 Gwynn Oak Ave. Hillsdale, Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2nd 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Elmer E. Parrish

11 BIRTHPLACE OF FATHER (city or town) Hillsdale (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ada E. Basford

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co. (State or country) Md.

14 Informant Elmer E. Parrish (Address) Hillsdale, Md.

15 Filed JUL 6 - 1921 ROBERT J. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1921

17

I HEREBY CERTIFY, That I attended deceased from June 30th, 1921, to July 4th, 1921, that I last saw him alive on July 4th, 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis - Acute Odema of Lungs

(duration) yrs. mos. 5 - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine and Microscopic

(Signed) A. C. Dennis, M. D.

July 7th 1921 (Address) 4509 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem.	July 7 1921

20 UNDERTAKER Jos. B. Cook ADDRESS 1003 N. Eutaw St.

CAUSE OF DEATH must be stated plainly, and the certificate must be signed and dated as directed. Neglect to do this will delay burial permit. Read carefully the rules on back of certificates. ATTENTION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition.

Frederick W. Heil

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55153

CERTIFICATE OF DEATH.

79 D 55153

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4 W. Echodale ST.) 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick W. Heil

(Residence in Baltimore: No. 4 W. Echodale ave Hamilton St.; 87 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 26 (Day), 1867 (Year)

7-AGE, 54 yrs. 2 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... 800

9-BIRTHPLACE. (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Mathew Heil

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Wirtwein

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Katherine Heil

(Address) 4 W. Echodale ave Hamilton

15- JUL 6 - 1921 ROBERT I KRAUSE

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) H. Ernest Kirby M. D.
(Coroner)

7-5, 1921. (Address) 4 W. Eclodale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, July 8th, 1921

20-UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

...—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55154

CERTIFICATE OF DEATH.

D 55154

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Hubbard ct ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Patterson

(a) RESIDENCE. NO. 1309 Hubbard ct ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? all yrs. all life ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Patterson

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Byron Wrenn

(Address) 1813 W. Fayette St

15 Filed JUL 7 - 1921 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3, 19 21, to ....., 19 ....., that I last saw her alive on July 3, 19 21, and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Several

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Failure of vital Organs

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) Murray Field Boyle, M. D.

7/7 19 21 (Address) 425 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL July 7 1921

20 UNDERTAKER Joseph A Farrell

ADDRESS 2014 Druid Hill Ave

CAUSE OF DEATH to be plainly written, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55155 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55155

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1743 argyle ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Loxedale

(a) RESIDENCE. NO. 1743 argyle ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
			1	12 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Loxedale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Queens, B.W.I.

12 MAIDEN NAME OF MOTHER W. Wilhelmina Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn N.Y.

14 Informant R. Wilhelmina Loxedale (Address) 1743 Argyle ave.

15 Filed JUL 7 1921, 19 G. H. Crest Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 21

17 I HEREBY CERTIFY, That I attended deceased from July, 19 21, to July, 19 21, that I last saw h-- alive on July, 19 21, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

1a Pernalus Bronchi

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Lunsford Richardson, M. D.

6/7, 19 21 (Address) 1743 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL July 7 1921

20 UNDERTAKER Jno. W. Johnson

ADDRESS 1234 Ellwood St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55156 | CERTIFICATE OF DEATH. | 104 D 55156

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 20 E. Heath St.; 23 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norma W Ruppert

(a) RESIDENCE. No. 20 E Heath St., 23 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13/1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Robt. Ruppert
11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md
12 MAIDEN NAME OF MOTHER Hilda Ryecke
13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Robt L Ruppert
(Address) 20 E Heath St.

15 Filed JUL 7-1921 C. H. Crese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1921, to July 6, 1921, that I last saw h[illegible] alive on July 5, 1921, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Convulsions (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinically
(Signed) H. L. Campbell, M. D.
July 6, 1921 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	7/7 1921
20 UNDERTAKER	ADDRESS
H. C. Kramer Son	703 Hanover St.

MAKE ENTRIES IN INK. WRITE PLAINLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF BIRTH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 55157

CERTIFICATE OF DEATH. X 64 D 55157

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1713 Clarkson ST.: (WARD) 7/9

2-FULL NAME. Andrew J. Brogan

(a) RESIDENCE. NO. 1713 Clarkson ST. 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Brogan

6 DATE OF BIRTH (month, day, and year) Dec - 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Theatres

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER James Brogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt Reedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Jos Trusler (Address) 1713 Clarkson St.

15 Filed JUL 7 - 1921 19 G. H. Grose Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1921

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1921, to July 2, 1921, that I last saw h alive on July 2, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. / ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H E Campbell M. D.

July 2, 19 21 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross adds	7/7/21 19
20 UNDERTAKER	ADDRESS
E & B Storck	115 E Lee

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55158 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55158

172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 523 N. Washington ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Louisl Earr

(a) RESIDENCE. NO. 523 N. Washington ST., 7 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Alex. R. Earr.

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired House

(b) General nature of industry, business, or establishment in which employed (or employer) Keeper. 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Ann E. Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Alexander R. Earr.

(Address) 523 N. Washington St.

JUL 7 - 1921

Received L. E. Wahl Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4- 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21 , 1921 , to July 4 , 1921.

that I last saw h-r alive on July 4 , 1921.

and that death occurred, on the date stated above, at 5 40/10 m.

The CAUSE OF DEATH* was as follows:

Fracture of hip Comminuted (Fall).

Hypostatic Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Fractured thigh

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) Edw Dalbrot, M. D.

7-4, 1921 (Address) 1353 W North Ave

*State the Disease Causing Death, or in Deaths from Violence, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (Use reverse side if additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetary	July 7- 1921

20 UNDERTAKER	ADDRESS
Lilly + Zeiler	4038 Wash Ave.

TION is very important. See instructions on back of certificates.

Dowd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55159

CERTIFICATE OF DEATH.

79 D 55159

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1st North Howard St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J. Dowd

(Residence in Baltimore: No. 228 Chester St.; 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Married

6-DATE OF BIRTH, Sept. 27, 1879
(Month) (Day) (Year)

7-AGE 41 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Produce
(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Martin Dowd

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Margaret Brann

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Dowd

(Address) 223 S. Chester St.

15-

Filed JUL 7-1919, 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5, 1919
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(Duration) 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) yrs. mos. ds.

(Signed) H. O'Malley, M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, 7/8, 1919

20-UNDERTAKER J. A. Moran

ADDRESS 300 E Baltimore

CAUSE OF DEATH to be plain terms, so that no doubt may be possible. Information important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Guerimore ✓

D 55160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 55160

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincent's Infant Home St.; 14th WARD)

2-FULL NAME Marcella L Guerimore

(a) RESIDENCE. No. St Vincent's Infant Home ST. [illegible] WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Nellie Lugenbuhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant St Vincent's Hospital
(Address) 1401 Division St

15 Filed JUL 7 - 1921 Issued [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to July 5, 1921, that I last saw h[illegible] alive on July 5, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas H Chaulter M. D.

6 Dec. 19 1 (Address) 15 W McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	July 7 1921

20 UNDERTAKER M Fahey & Sons ADDRESS 1827 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55161

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55161

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Washington Park ST.; 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Galkauskas

(a) RESIDENCE. NO. Washington Park. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs — mos — ds. How long in U. S., if of foreign birth? 17 yrs — mos — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Lithuania

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Anton Galkauskas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Elizabeth Palonis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant George Galkauskas
(Address) Washington Park

15 JUL 7 - 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to July 6, 1920, that I last saw him alive on July 6, 1920, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm. H. Cox, M. D.

7/7, 1920 (Address) 545 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 8 1920

20 UNDERTAKER	ADDRESS
John Grebliunas	425 S. Pac[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-5-19—H. P. Co.—1000 Bks.

Grese D 55162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 55162

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3426 E. Pratt St.: 26 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Trotta

(a) RESIDENCE. No. 3426 E. Pratt St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year): May 6th 1921

7 AGE — Years: — Months: 2 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Carmine Trotta

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Filomena Di Reggione

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Carmine Trotta (Address) 3426 E Pratt St

15 Filed: JUL 7- 1921 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1921, to July 5, 1921, that I last saw h[illegible] alive on July 5, 1921, and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Icterus Neonatorum

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. E. Marr, M. D.

19 21 (Address) 827 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. — DATE OF BURIAL: July 7 19 21

20 UNDERTAKER: J. Herring & Co — ADDRESS: 700 Wilkens

CAUSE OF DEATH in plain terms, so that it may be understood by registrars of certificates. TION is very important. See instructions on back of c

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-55163 ✓ 28

CERTIFICATE OF DEATH.

D-55163

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO. 743 Ryan ST.: 21 WARD)

(Usual place of abode)

2-FULL NAME Fannie Jones

(a) RESIDENCE. NO. 743 Ryan ST.. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of West Jones

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic Duties

(b) General nature of industry, business, or establishment in which employed (or employer): General House work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Osborne Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Adam Beel 124 W Hughes St

15 FILED JUL 7 - 1921 19 L. E. Wohlt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/5/21

17 I HEREBY CERTIFY, That I attended deceased from 5/5/21 to 7/5/21

that I last saw h alive on 7/5/21

and that death occurred, on the date stated above, at 10.01 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

about 2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colds & Exposure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) X. Gus Bowley M. D.

7/6/21 (Address) 908 Shard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	July 8 1921

20 UNDERTAKER ADDRESS

C C Gross 1405 McElderry St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D [redacted]

D 55164

CERTIFICATE OF DEATH.

120

D [redacted]

D 55164

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 N. Edon ST., 10 WARD)

2-FULL NAME Calvin McPett

(a) RESIDENCE NO. 623 N Edon ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Etta McPett

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Hauling sand

(c) Name of employer Frederick Lane

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Charles McPett

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown

14 Informant Etta McPett

(Address) 623 N. Edon St

15 Filed JUL 7 - 1921, 19 ..... Registrar I. E. Webb

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1921, to July 4, 1921.

that I last saw h— alive on July 4, 1921.

and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

Duration

(duration) 9 mos yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Kidney analysis

(Signed) R. Garland Upshur M. D.

July 6 1921 (Address) 1534 E. Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL July 7 1921

20 UNDERTAKER R C Gross

ADDRESS 1405 McElderry

CHECK OF CERTIFICATE. TION is very important. See instructions on back of certificates.

v

Form. 6-9-19 H. P. Co.—1000 Bks.

D 55165

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55165

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Raspeburg, Baltimore Md.

CITY OF BALTIMORE: (No. Benton Heights Ave Nr White ST. 4 WARD)

2-FULL NAME Mrs Elizabeth Lock

(a) RESIDENCE. NO. Benton Heights Ave Nr Hanover ST. WARD.

(Usual place of abode) Raspeburg Baltimore Md (If nonresident give city or town and State)

Length of residence in city or town where death occurred All her life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry J Lock

6 DATE OF BIRTH (month, day, and year) Sept 5-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework Odd Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Grebe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Klopfer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna B Wallis

(Address) 524 E Eutaw St

Filed JUL 7-1921, 19 G. H. Gresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from October 13, 1920, to July 6, 1921, that I last saw h.er alive on July 6, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus
(Diabetic Coma)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus
(Diabetic Coma) (duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Gorn, M. D.

7/6, 1921 (Address) Hamilton Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	July 9th 21
20 UNDERTAKER Bertram L Gore	ADDRESS 1751 Lafayette

TION is very important. See instructions on back of certificates.

1

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55166

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55[illegible]6

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1439 Columbia Ave., ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Podgurski

(a) RESIDENCE. No. 1439 Columbia Ave? ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Podgurski

6 DATE OF BIRTH (month, day, and year) July 24th 1862

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Julius May

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Koloski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Kelfer (Address) 331 S. Furrow St.

15 Filed JUL 7-1921 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1-1920 19.. to July 6 , 1921, that I last saw her alive on July 6 , 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy Heart

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dorsey, M. D.

, 19 (Address) 1276 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL July 9 1921

20 UNDERTAKER Joseph B. Cook

ADDRESS 1002 N. Balto St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Bayne

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55167

CERTIFICATE OF DEATH.

1576 55167

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 611- McCabe Ave St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E. Payne

(Residence in Baltimore: No. 611- McCabe Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, July (Month) 6th (Day), 1921 (Year)

7-AGE, yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John E. Payne

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Mary Sullivan

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Payne

(Address) 611 McCabe Ave

15- JUL 7 - 1921

Filed ..., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 6 1921, to July 6 1921, that I saw him alive on July 6 1921, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

General weakness -
lived but 15 minutes

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Difficult birth

(Duration) yrs. mos. ds.

(Signed) E. H. Duncan M. D.

July 7, 1921. (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. 7/7/21

20-UNDERTAKER Geo. J. Ruth ADDRESS 1735 Hanford Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55168 ✓ 40 D 55168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1341 Hull ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer E. Ellsworth Gloman

(a) RESIDENCE. NO. 1341 Hull ST., 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed,~~ or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna L. Gloman

6 DATE OF BIRTH (month, day, and year) April 16, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) O I

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER George W Gloman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Eliza Nagle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Anna L. Gloman

(Address) 1244 Edmondson Ave

15 Filed JUL 7-1921 19 Registrar

Burial (or Removal) Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1 1921, to July 6 1921, that I last saw him alive on July 6 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Sidney H. Streett, M. D.

7/7. 1921 (Address) 4 W Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	July 9. 1921

20 UNDERTAKER Mrs J. E Evans & Son ADDRESS 1425 N Charles

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55169

CERTIFICATE OF DEATH.

28 D 55169

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Bay View Hosp. M. T. St. ST.: 11 26th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Hill.

(a) RESIDENCE. NO. 246 W. Biddle ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Bl	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) May 6 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Bouldin Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Frances Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hospital Records

(Address)

15 Filed JUL 7 - 1921 19 ROBERT J. KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1921

17

I HEREBY CERTIFY, That I attended deceased from July 2nd, 19 21, to July 3rd, 19 21, that I last saw him alive on July 3rd, 19 21, and that death occurred, on the date stated above, at 9 50 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam of the sputum & X-ray

(Signed) Dr. P. Mendola, M. D.

19 (Address) Bay View Asylum, Path. Dept.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

JUL 7 1921

Commissioner Health.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55170

151 D 55170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 Myrtle ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bailey

(a) RESIDENCE. No. 512 Myrtle Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	B	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 3 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ddd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER John Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Emma Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant From Birth Certificate

(Address) 512 Myrtle Ave

15 Filed JUL 7-1921 ROBERT I. GAITHER Registrar Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1921, to July 4, 1921, that I last saw her alive on July 4, 1921, and that death occurred, on the date stated above, at 2.35 P m.

The CAUSE OF DEATH* was as follows:

Premature - 5 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) John R Bailey, M. D.

, 19 (Address) 723 George

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JULY
20 UNDERTAKER	ADDRESS

JUL

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 55171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55171

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2414 Ashland Ave. (St.) 7 (Ward)

2-FULL NAME Jennie Downsend

a) RESIDENCE NO. 2414 Ashland Ave. (Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Downsend

6 DATE OF BIRTH (month, day, and year): Jan 15 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23 - 23	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Boheme

PARENTS

10 NAME OF FATHER: Joseph Vacousek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Barbara Hely

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Boheme

14 Informant (Address): Chas. M Downsend 2414 Ashland Ave

15 Filed JUL 7 - 1921 ROBERT I. [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20 1921, to July 5 1921, that I last saw h[illegible] alive on July 5 1921, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary): Cardiac Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Ramsey, M. D.

(Address) 801 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	July 8. 1921

20 UNDERTAKER: Hurt Enoch & Son ADDRESS 1106 Eutaw

FOR INSTRUCTIONS AND FORMS FOR CERTIFICATES, SEE BACK OF THIS SHEET

IMPORTANT—READ CAREFULLY BEFORE FILLING OUT CERTIFICATE

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55172

CERTIFICATE OF DEATH.

104 D 55172

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 762 W. Franklin ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Elz. Mead

(Residence in Baltimore: No. 762 W. Franklin St. 1 yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, April 27, 1920 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
1 yrs. 2 mon. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Infant

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Betty Mead

(Address) 762 W. Franklin St

15-

Filed JUL 7 1921 ROBERT I. KRAUTH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Gastro Enteritis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. A. Hennessy M. D. (Coroner)

July 7 1921 (Address) 2802 Eastfordham

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	July 8. 1921.
20-UNDERTAKER Katie R. Williams	ADDRESS 1114 W. Saratoga St.

Please answer all questions in full, so far as they may be applicable. Where the space provided is insufficient, use the margin. Typewriting is preferred, but if ink is used, PRINT plainly. Do not use pencil. Be sure to sign certificate in ink. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55173

CERTIFICATE OF DEATH.

15 - 61

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2804 Rockrose Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laetitia Virginia Vogel

(a) RESIDENCE. NO. 2804 Rockrose Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ...yrs. ...mos. ...ds. How long in U. S., if of foreign birth? ...yrs. ...mos. ...ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Christian Vogel

6 DATE OF BIRTH (month, day, and year) Oct., 25th. 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	33	8	11	

8 OCCUPATION OF DECEASED

037

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John H. Riehl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary P. Sprowl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Ethel B. Bautz
(Address) 2504 Rockrose Ave.

15 Filed JUL 7 - 1921 [illegible] REGISTRAR

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July, 6th. 1921

17

I HEREBY CERTIFY, That I attended deceased from June 20 . 1921 . to July 6 . 1921 .

that I last saw h e alive on July 6 . 1921 .

and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Meningitis -

fvr.

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home on work

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. N. Bickley . M. D.

. 19 (Address) 126 W. Belvedere

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	7/9 1921
20 UNDERTAKER	ADDRESS
E. J. Evans & Son	118 N Mt Royal Ave

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Simple idiopathic meningitis

Spec. 6-9-19 H. P. Co.—1000 Blks.

D 55174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20 D 55174

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonio Lanasa

(a) RESIDENCE. NO. Raleigh Ave ST. Roland Park WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
m	W.	S.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept 23-1908

7 AGE Years	Months	Days	If less than 1 day, hrs. or min.
12	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Antonio Lanasa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Passero

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Agnes Lanasa Raleigh Ave Roslyn Park

15 JUL 7-1921 BOARD OF HEALTH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1921, to July 4, 1921, that I last saw h alive on July 4, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Acute

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Septicaemia Infected Ankle (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of July 1-21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. Mann M. D.

(Address) 18 Park & Penn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	7/8 1921
20 UNDERTAKER Chas D Evans & Sons	ADDRESS

THON is very important. See instructions on back of

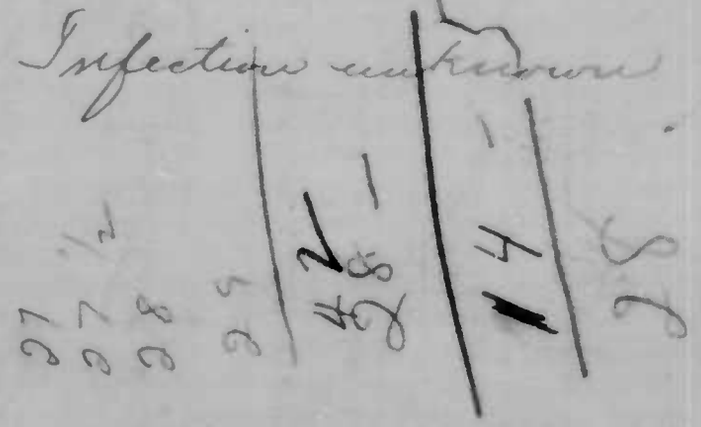
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.



Spec.—1-10-21 M&T 1500 Blks.

D 55175

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 55175

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. PUBLIC HEALTH HOSP. #56

CITY OF BALTIMORE: (No. FORT MCHENRY BALTIMORE MD ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ROY WHITE

(a) RESIDENCE No. U.S. PUBLIC HEALTH HOSP. #56 FT. MCHENRY ST. BALTIMORE MD. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	SINGLE

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) UNKNOWN

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	22 YRS.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work FARMER. 186

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) INDIANA

PARENTS

10 NAME OF FATHER UNKNOWN

11 BIRTHPLACE OF FATHER (city or town) (State or country) UNKNOWN

12 MAIDEN NAME OF MOTHER UNKNOWN

13 BIRTHPLACE OF MOTHER (city or town) (State or country) UNKNOWN

14 Informant EDGAR T ROSENBROCK REGISTRAR

(Address) U.S. PHS HOSP #56 Fort McHenry Md.

15 JUL 7 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JULY 5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3. 1921 to July 5 1921.

that I last saw him alive on July 5 1921.

and that death occurred, on the date stated above, at 2'10 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far. adv. active.

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) --- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ----

Was there an autopsy? No

What test confirmed diagnosis? Exam / Clinic report

(Signed) Thomas H. Paynter M.D.
Senior Surgeon (R)

, 19 (Address) U.S. PHS Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lawnby Cemetary

DATE OF BURIAL July 8 1921

20 UNDERTAKER S. Lennon

ADDRESS 1127 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55176

CERTIFICATE OF DEATH.

D 55176

1-PLACE OF DEATH U.S.P.H.S. Hospital #56, Baltimore, Md.. REGISTERED NO.

CITY OF BALTIMORE: (No. Ft. McHenry, Baltimore, Md ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gallagher, Peter A.

(a) RESIDENCE NO. U.S.P.H.S. Hospital #56, Baltimore, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	27	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 086

(b) General nature of Industry, business, or establishment in which employed (or employer) --

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T. Rowbrock MD

(Address) Registrar, USPHS Hosp #56

15 Filed JUL 7 - 1921 BOYER & BAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/7/21 19

17

I HEREBY CERTIFY, That I attended deceased from Feb. 4, 21 to July 7, 1921 .19 .

that I last saw him alive on July 7, 1921 .19 ,

and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Fistula in Ano

-- (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Surgical shock

(duration) yrs. 5 mos. - ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 7/7/21

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Thomas R. Rowbrock M. D.

7/7. 1921 (Address) Senior Surgeon USPHS Hospital #56

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Scranton Pa DATE OF BURIAL July 7 1921

20 UNDERTAKER Sol Quinn ADDRESS 1127 E Biddle St

CAUSES OF DEATH should be properly classified. See Manual of Classification on back of certificates.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55177

CERTIFICATE OF DEATH.

D 55177

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 911 N. Patrick St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. H. Smith

(Residence in Baltimore: No. 911 Patrick St., St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	colored	married

6-DATE OF BIRTH, ... November, 1883
(Month) (Day) (Year)

7-AGE, 38 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 083
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Stock)

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Warner

(Address) 911 Patrick St.

15-

Filed ..... 191. ROBERT J. KRAUTER ..... Registrar.

JUL 7 - 1921

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Hist history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Hennessy M. D.
(Coroner.)

July 7, 1921 (Address) 2817 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, July 9 1921

20-UNDERTAKER Sam'l W. Chase & Son

ADDRESS 1400 Madison

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55178

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 207 Arisquith St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Henry

(a) RESIDENCE. No. 207 Arisquith St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev Jno H Henry

6 DATE OF BIRTH (month, day, and year) Jan 20 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper at Colored Church home Arisquith St

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Hiram Mathews Pa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frances Peoples Pa

12 MAIDEN NAME OF MOTHER Frances Peoples

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown Pa

14 Informant, (Address) Frances E Davis 1843, N. Spring

15 Filed JUL 7 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 6 1921, that I last saw her alive on July 5 1921, and that death occurred, on the date stated above, at 9 am m.

The CAUSE OF DEATH* was as follows:

acute Insufficiency

Interval (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Summer heat 7 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Edward Fisher M. D.

7-7 1921 (Address) 1612 E monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 8 1921
20 UNDERTAKER Sam'l W. Chase Sons	ADDRESS 1400 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease alone is not sufficient. Whether primary, secondary or contributory, should be stated. OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55179

CERTIFICATE OF DEATH.

D 55179

114

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 Park Ave. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Rebecca Kelly

(a) RESIDENCE. NO. 1425 Park Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 6"

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Patrick Kelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) U. S.

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) U. S.

14 Informant Mr. Wm. M. Justis
(Address) 1415 Park Ave.

Filed JUL 7 - 1921, 19

WEBER & FRAUTER Registrar

Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5" 1921

17 I HEREBY CERTIFY, That I attended deceased from June 14th, 1921, to July 5th, 1921, that I last saw her alive on July 5th, 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Gall. Stones = Gastro. enteritis.

(duration) — yrs. — mos. 16 ds.

CONTRIBUTORY (Secondary) Exposure heat = Exhaustion

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Place of Death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wayne D. Perkins, M. D.

, 19 (Address) 1 N. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	7/8/21 19 21

20 UNDERTAKER Joseph B. Cook ADDRESS 1009 N. Balto.

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

BERGER

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55180

CERTIFICATE OF DEATH.

170 D 55180

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Olivia Berger

(Residence in Baltimore: No. Assumption St. & Ashland Ave St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, September 8, 1853
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
67 yrs. 9 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)..... 068

9-BIRTHPLACE, (State or Country), Albany N. Y.

PARENTS.

10-NAME OF FATHER, John Berger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Schaefner

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Dionesia

(Address) Asquith & Ashland Ave.

15-

Filed JUL 7-1921, 191.... ROBERT J. BRUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 6, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 1916, to July 1921, that I saw her alive on July 6 - 1921, and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion Asthenia Edema

Chronic Nephritis

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.

July 7, 1921 (Address) 1106 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Notch Cliff Md	July 9, 1921
20-UNDERTAKER	**ADDRESS**
Frank A. Finke	915 N. Gay St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55181 — 120 D 55181

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12th Ave. + 29th St. Colgate ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George Fink

(a) RESIDENCE. NO. 12th Ave. + 29th St. Colgate ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Fink

6 DATE OF BIRTH (month, day, and year) May 31-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	72	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Miller Chemical Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Elizabeth Fink
(Address) 12th Ave + 29th St Colgate

15 Filed JUL 7 - 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1920, to July 6, 1921, that I last saw h.i.m alive on July 6 (nm), 1921, and that death occurred, on the date stated above, at 10 25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis with Pericystal degeneration both kidneys. + mitral regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Small area of L. lung congestion Probably traumatic (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Inspection.

(Signed) A H Stansbury, M. D.

7/7. 1921 (Address) 714 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cemetery	July 11 1921
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill; (a) Salesman*, (*b*) *Grocery; (a) Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Abt 9 mos ago fell
& fractured left

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 55182

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 N. Grantford Ave ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Pasters.

(a) RESIDENCE. No. 416 N. Grantford ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose E. Pasters

6 DATE OF BIRTH (month, day, and year) May 27-1845

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
76	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jos Miller

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Maud Leib (Address) 416 N. Grantford ave

15 Filed JUL 7-1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5 1921, to July 6 1921, that I last saw h[illegible] alive on July 6 1921, and that death occurred, on the date stated above, at [illegible] p. m.

The CAUSE OF DEATH* was as follows:

Gastro Entero Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 6M yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph D. Talkin, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	July 8 1921
20 UNDERTAKER	ADDRESS
Hans Christian Muller	2334 Jefferson

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

55183 HEALTH DEPARTMENT—CITY OF BALTIMORE 55183

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 3 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Josephine Werner.

(a) RESIDENCE. No. 870 So. Dallas St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs 0 mos 0 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — — 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Henry Mosotky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

11 Informant Marcin Werner

(Address) 870 S. Dallas St.

15 Filed JUL 8 1921 G. H. Crosse. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1921, to July 7, 1921, that I last saw her alive on July 7, 1921, and that death occurred, on the date stated above, at 5:40 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms —

(Signed) John J. Conlon, M. D.

7/7, 1921 (Address) Emerson Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL July 9 1921

UNDERTAKER — ADDRESS

William F. Ellsworth 1611 Eastern Ave

TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

Grese 55184

HEALTH DEPARTMENT—CITY OF BALTIMORE

55184 — 55184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 91 — D 55184

CITY OF BALTIMORE: (No. 37 42d Ave East Brooklyn WARD) 25

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislawa Smielinska

(Residence in Baltimore: No. 37-42d Ave East Brooklyn St.: 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, March 7, 1920 (Month) (Day) (Year)

7-AGE, 1 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country) East Brooklyn New

PARENTS.

10-NAME OF FATHER. Leon Smielinski

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Mary Rybicka

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leon Smielinski

(Address) East Brooklyn

15-

Filed JUL 8 1921 G. H. Grese, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 6 1921, to — 191, that I saw her alive on July 6 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Malnutrition

Premature (7 months) (Duration) yrs. 1 mos. ds.

(Signed) Leon J. Hosica M. D.

July 7, 1921 (Address) Curtis Bay, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Cross — DATE OF BURIAL, 7/8, 1921

UNDERTAKER Wm Falkowski — ADDRESS 618 Eastern Ave.

important. See instructions on back of certificate.

Grace 55185 HEALTH DEPARTMENT—CITY OF BALTIMORE 55185

CERTIFICATE OF DEATH.

183 D 55185

D 55185

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2/12 & oak. ST. 12th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George P. Johnson.

(Residence in Baltimore: No. 120 W 23rd St. St. (yrs. 12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6-DATE OF BIRTH, Jan. 1, 1886 (Month) (Day) (Year)

7-AGE, 35 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE, (State or Country): Caroline Co. Va.

PARENTS.

10-NAME OF FATHER: Daniel Johnson

11-BIRTHPLACE OF FATHER (State or Country): Va

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen M. Johnson

(Address) 120 W. 23rd St

15-

Filed JUL 8 1921 191.... G. H. Gross Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 4, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Stab wounds in his neck from a razor (Murder)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Haussler M. D. (Coroner.)

July 6 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL: Fredericksburg Va. DATE OF BURIAL, July 8 1921

20-UNDERTAKER: Daniel Gormley ADDRESS 518 N Eden St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

55186 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 55186

D 55186

CERTIFICATE OF DEATH.

X 40 D 55186

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Agnes Hosp. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna O'Toole.

(a) RESIDENCE. NO. Thurmont, Md. ST.. WARD. Thurmont Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 16 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced (or) WIFE of: Richard J. O'Toole

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Household.

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): " " "

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " " "

14 Informant: Dr Bernard O'Leal

(Address): Thurmont Md

15 Filed ....., 19 JUL 8 1921 Registrar C. H. Gross.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1921

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1921, to July 7- , 1921, that I last saw her alive on July 7- , 1921, and that death occurred, on the date stated above, at 9 20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma gall bladder.

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Myocardial insuff.

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Dudley P. Bowes, M. D.

19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Thurmont Md	July 9 1921

20 UNDERTAKER: Chas. S. Black ADDRESS: 742 W. North Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55137 D 55187 D 55187 D 55187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 7

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 N Chester ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie L. Hall

(Residence in Baltimore: No. 13 N. Chester St.: 67 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, June (Month) 9 (Day), 1854 (Year)

7-AGE, 67 yrs. ..... mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, James Fields

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER King

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS ~~TRUE~~ TO THE BEST OF MY KNOWLEDGE.

(Informant) F. A. Hall

(Address) 13 N. CHESTER St

15-

Filed JUL 8 1921 Registrar.

G. H. G...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 6 1921, that I saw her alive on July 5 1921, and that death occurred, on the date stated above, at 5.50 a. m.

The CAUSE OF DEATH* was as follows:

Heat Stroke

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Arthritis deformans

..... (Duration) 10 yrs. 6 mos. .....

(Signed) E. B. Britton M. D.

July 8, 1921. (Address) 1711 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, July 9, 1921

20-UNDERTAKER Robert Brockum ADDRESS Calhoun & Hollins

Important: See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55188

CERTIFICATE OF DEATH.

ngv 55188

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 915 St Barnabas Ct ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Ridout

(Residence in Baltimore: No. 915 St Barnabas Ct St.; 67 yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ... — (Month) — (Day) 1854 (Year)

7-AGE, 67 yrs. — mos. — da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook 67
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private Cook

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno W Brown

(Address) 915 St Barnabas Ct

15- JUL 8 1921, 191.... G. H. Grace Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 6th (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26th 1921, to July 6th 1921, that I saw her alive on June 28 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... Pernicious Anaemia

..... (Duration) — yrs. — mos. 10 da.

CONTRIBUTORY (Secondary) Chronic Prostration

..... (Duration) — yrs. — mos. 10 da.

(Signed) Edward E Wallace M. D.

July 8, 1921, (Address) 1359 W Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, National Cemetery — DATE OF BURIAL, 7/8/21 191...

20-UNDERTAKER Philip B Ryan — ADDRESS 702 E Fayette St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Joseph Mason

D 55189 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55189

CERTIFICATE OF DEATH. x 64

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 1302 Laurens ST., 15 WARD)

2—FULL NAME Joseph mason George Mason

(a) RESIDENCE No. 1302 Laurens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St Mary Co Md

PARENTS

10 NAME OF FATHER Abram Mason

11 BIRTHPLACE OF FATHER (city or town) St (State or country) Mary Co Md

12 MAIDEN NAME OF MOTHER Cecilia Thomas

13 BIRTHPLACE OF MOTHER (city or town) St Mary (State or country) Co Md

14 Informant Mary Thomas (Address) 1302 Laurens St

15 Filed — 19 G. H. Gresse Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7—1921

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to July 7, 1921, that I last saw him alive on July 7—, 1921, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

Asthma & Dropsy. (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Asthma & Dropsy. (duration) yrs. 3 mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D. W. Kennard M. D.

7-8-1921 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mechanicsville Md	July 9 1921
20 UNDERTAKER Joseph L. Farrell	ADDRESS 2819 Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55190

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55190

CERTIFICATE OF DEATH.

64-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2405 Lafayette ave (St.) 13 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Blaustein

(a) RESIDENCE. NO. 2405 Lafayette Ave ST.... WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8/1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	3.	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Blaustein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Taubee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant M. Blaustein

(Address) 2405 Lafayette ave

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1921, to July 6, 1921, that I last saw h... alive on July 6, 1921, and that death occurred, on the date stated above, at 10:40 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia. (Right)

(duration) yrs. 3 mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Joseph William Kelly, M. D.

7/7, 1921 (Address) 2327 Curtain Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew Cemetery	July 8 1921
20 UNDERTAKER Mat Lurson	ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55191

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1535 Bruce St. 15 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Chase

(a) RESIDENCE. NO. 1535 Bruce St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1, 19 19

7 AGE 2 Years 3 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nora McCormick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington

14 Informant Mother Chase

(Address) 1535 N Bruce St

15 Filed JUL 8 1921 19 G. H. Grosse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 24, 19 21, to July 6, 19 21, that I last saw him alive on July 6, 19 21, and that death occurred, on the date stated above, at 3.40 p m.

The CAUSE OF DEATH* was as follows:

Ac Catarrhal Enteritis

(duration) mos. 10 ds.

CONTRIBUTORY (Secondary) Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cannot say

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Eaw Short M. D.

July 19 21 (Address) 1 E Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: July 8 19 21

20 UNDERTAKER James H Dennis ADDRESS Preston

TION is very important. See instructions on back of certificates.

...—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55192 John Milton Reid Jr 30-B 55192

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1035 N Carey ST.; 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Milton Reid Jr.

(a) RESIDENCE. NO. 1035 N Carey ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9. 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	8	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Jas. M Reid

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Rottley

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Jas M Reid
(Address) 1035 N Carey

15 Filed ... 19... G. H. Gresse. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to July 5, 1921, that I last saw him alive on July 4, 1921, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Meninges

(duration) ... yrs. ... mos. 30 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia in Feb 1921

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. S. McCard, M. D.

7/7, 1921 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	July 8 1921

20 UNDERTAKER James H Dennis ADDRESS 1303 Pennsylvania Ave

TION is very important. See instructions on back of certificates.

C. H. Cresse

S. & A. 15—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55193

CERTIFICATE OF DEATH.

79 D 55193

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1681 Cliftview Ave St. 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Stout

(a) RESIDENCE. NO. 1681 Cliftview Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew J. Stout

6 DATE OF BIRTH (month, day, and year) May 15th 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	88	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 600

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Franklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mc Kown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs. Jennie Stevens

(Address) 1681 Cliftview Ave

15 Filed JUL 8 1921 19 G. H. Cresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3 1921, to July 7 1921, that I last saw h.. alive on July 7 1921, and that death occurred, on the date stated above, at 11 00 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jacob Fisher M. D.

7/8. 1921 (Address) 1823 N. Hunt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	July 9th 1921
20 UNDERTAKER	ADDRESS
Geo M. Frick & Son	811 N Wolfe

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Roger O'Dea.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55194

CERTIFICATE OF DEATH.

120 D 55194

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 509 South ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roger ADea

(a) RESIDENCE. No. 509 South ST., 21 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. ADea

6 DATE OF BIRTH (month, day, and year) Nov 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thos ADea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary J ADea (Address) 509 South St

15 Filed JUL 8 1921, 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1921, to July 7, 1921, that I last saw h in alive on July 7, 1921, and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Thrombosis

(duration) 6 yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 6 yrs. 6 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Cantlon, M. D.

7/8, 1921 (Address) 517 South St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 10 1921

20 UNDERTAKER ADDRESS

W. P. Cook 502 E North Ave

TION is very important. See instructions on back of certificates.

Gross

D 35195

184

6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 35195

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *So Balto Gen Hosp* St. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Nannie V. Harrison*

(a) RESIDENCE. NO. *1528 E Biddle* ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. mos. ds. How long in U. S., if of foreign birth? *Life.* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	*Wh*	*M.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Leslie D Harrison*

6 DATE OF BIRTH (month, day, and year) *Apr 1st 1883*

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	*3*		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Home* 37

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) *Md.*

PARENTS

10 NAME OF FATHER *Chas F. Howett*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *Charlotte E. Covington*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14 Informant *Mrs Leslie Harrison*

(Address) *1828 E Biddle St*

15 Filed JUL 8 1921 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 7* 1921

17 I HEREBY CERTIFY, That I attended deceased from *June 19* 1921, to *July 7* 1921.

That I last saw h*e*r alive on *July 7* 1921, and that death occurred, on the date stated above, at *7 45* .....m.

The CAUSE OF DEATH*, was as follows:

Acute Hemorrhagic Nephritis

2 wks. 0737

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Uremia*

(duration) yrs. mos. *10* ds.

18 Where was disease contracted if not at place of death? *1528 E Biddle St*

Did an operation precede death? *No* Date of

Was there an autopsy? *yes partial*

What test confirmed diagnosis?

(Signed) *R. W. Johnson* M. D.

, 19 (Address) *So Balto Gen Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudenschlager Md	*Jul 8* 1921
20 UNDERTAKER	ADDRESS
William Cook	*1028 Mott St*

(over)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55196

CERTIFICATE OF DEATH.

14 1206 55196

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 Madison Ave. ST. 14 WARD)

2-FULL NAME George E. Rodgers

(a) RESIDENCE. NO. 1814 Madison Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine A. Rodgers

6 DATE OF BIRTH (month, day, and year) Nov. 21" 1840

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	7	15	

8 OCCUPATION OF DECEASED 008

(a) Trade, profession or particular kind of work Retired Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) William H. Whitridge

(c) Name of employer Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Catherine A. Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant William H. Ryan

(Address) 1814 Madison Ave.

15 Filed JUL 8 1921 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6" 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1921, to July 6, 1921, that I last saw h im alive on July 5, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) , yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Lamy Hessman, M. D.

July 7, 1921 (Address) 2687 Wiltens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 9" 1921
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W Balto St

This is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sohle Sohl

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55197 D 55197

CERTIFICATE OF DEATH.

15 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 Mt Clair Lane 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Sohn

(a) RESIDENCE. NO. 334 Mt Clair Lane ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 7 74

7 AGE	Years	Months	Days	If LESS than 1 day 17 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Carl Sohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Hattie Vaelkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Mrs C. Sohn
(Address) 334 Mt Clair Lane

15 Filed JUL 8 1921 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1921, to July 7, 1921.

That I last saw him alive on July 7, 1921,

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Premature Delivery
at 7th Month

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. W. Jones, M. D.

(Address) July 8 1921 Dr. Langston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 8 1921

20 UNDERTAKER C. W. Dill ADDRESS Frederick Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55198 — 79 — D 55198

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 238 N. Bond (St.:) 6 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Louis Gesberg

(a) RESIDENCE. No. 238 N. Bond St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Lotie Elizabeth Gesberg

6 DATE OF BIRTH (month, day, and year) June 9/54

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Baker 003

(b) General nature of industry, business, or establishment in which employed (or employer): Himself

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Louis Gesberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Annie Gesberg 238 N. Bond St.

Filed JUL 8 1921 G. H. Gress, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-12- , 1921, to 7-7- , 1921, that I last saw h[illegible] alive on 7-6- , 1921, and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic insufficiency
Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What leal confirmed diagnosis? Physical Signs

(Signed) Solomon E. Katz M.D. M. D.

, 19 (Address) 116 Fitzgerald St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	July 9 1921
20 UNDERTAKER: Philip Herrig	ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55199

CERTIFICATE OF DEATH.

1040 D 55199

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2002 Eastern Av (St.) V (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. J. Rodolney Jr.

(a) RESIDENCE (Usual place of abode) No. 2002 Eastern St. Ward

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs 11 mos 7 ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): aug 1/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balty

PARENTS

10 NAME OF FATHER: Chas. J. Rodolney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Madge Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Madge Rodolney

(Address) 2002 Eastern av

15 Filed JUL 8 1921, 19

G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1921, to July 7, 1921.

That I last saw him alive on July 7, 19

and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): acute Bronchitis

(duration) yrs mos 7 ds

18 Where was disease contracted if not at place of death? at Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Wm. H. Watkins, M. D.

7/7, 1921 (Address) 330 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: July 9 1921

20 UNDERTAKER: Philip Henrig — ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55200

CERTIFICATE OF DEATH.

80 D 55200

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310 E. Baltimore ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua D. Taylor

(a) RESIDENCE. NO. 2310 E. Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha B. Taylor

6 DATE OF BIRTH (month, day, and year) Dec 30. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper 108

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 2 years

(c) Name of employer City Balto

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Milton M. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Nugent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant (Address) Martha B. Taylor 2310 E. Baltimore St

15 Filed JUL 8 1921, 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1920, to July 6, 1921, that I last saw h— alive on July 6 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris —
(Mg. arteries)
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cortical Paralysis
(duration) yrs. mos. 2 hrs.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dr. P. Bowman, M. D.

7/8, 1921 (Address) 125 S. Bolton —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	July 9 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1310 Madison

CAUSE OF DEATH to print items, so that it may be of certificates.
TION is very important. See instructions on back of cer

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55201 (Cross) 50D 55201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4825 Park Heights Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia M. H Heing.

(a) RESIDENCE NO. 4825 Park Heights Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of William G H Heing.

6 DATE OF BIRTH (month, day, and year) Nov 29 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) c

(c) Name of employer c

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Julius Conrad

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country) Not Known

12 MAIDEN NAME OF MOTHER ~~Germany~~

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs Edw M Cumeling (Address) 4825 Park Heights Ave

15 Filed JUL 8 1921 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1921, to 7-7, 1921, that I last saw ~~He~~ alive on 7-6, 1921, and that death occurred, on the date stated above, at 8 55 ~~P~~ A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Multiple

(duration) 6 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cellulitis Heal

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Metastatic

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. G. Parnell M. D.

, 19 (Address) 2100 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL 7-9 1921

20 UNDERTAKER Wm Chas A G Rohde ADDRESS 1007 Arlington Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55202

CERTIFICATE OF DEATH.

79 D 55202

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 603 W. Lee St. St. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Zadock Duvall.

23 ------- St.; yrs., mos. ds.)

(Residence in Baltimore: No. 603 W. Lee St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, April 12th. 1850., 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
71 yrs. 2 mos. 24 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), A. A? Co. Md.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Ostendorf.

(Address) 603 W. Lee St.

15-

Filed ..... 191.....

JUL 8 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 6th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis, Myocardial Insufficiency, Senile Dementia.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

July 7., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	7-9, 1921
20-UNDERTAKER	ADDRESS
E. H. B. Hartel	115 E. Wood St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55203

CERTIFICATE OF DEATH.

28D 55203

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tbc Hosp. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walker Young

(a) RESIDENCE. NO. 630 Lakewilloux ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of ~~[illegible]~~ of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
30				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Unknown

14 Informant Hospital Records (Address)

15 Filed JUL 8 1921 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from June 23 1921, to July 6 1921, that I last saw h[illegible] alive on July 6 1921, and that death occurred, on the date stated above, at 3 15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Positive Sputum

(Signed) Alfred Morrell, M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	July 8 1921

20 UNDERTAKER Samuel Newsley ADDRESS 5[illegible] N Bond St

CAUSE OF DEATH to be plainly stated. Use terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55204

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf. ST.: 6 WARD)

2-FULL NAME Baby John Whitham.

(a) RESIDENCE. NO. 3934 Clover Hill St. Road WARD.
(Usual place of abode) Balto. Md.
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 25th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Lloyd B Whitham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Ridgely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hosp. Record.
(Address)

15 Filed JUL 8 1921 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1921, to July 6, 1921, that I last saw him alive on July 6, 1921, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Birth injury - Clinically intra cranial hemorrhage

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Congenital pyloric atresis operation (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes - Date of July 4-1921

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical diagnosis not confirmed by autopsy

(Signed) W. E. Noble, M. D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	July 8th 1921

20 UNDERTAKER Henry W. Jenkins Sons ADDRESS McCulloh & Orchard

CAUSE OF DEATH must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Kohl.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55205

D 55205

CERTIFICATE OF DEATH.

177

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph G. Kohl Sr.

(a) RESIDENCE. NO. 1626 E. Hoffman ST. St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Kohl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Magdalen Kohl
(Address) 1626 E Hoffman

15 Filed JUL 8 1921 BOARD OF HEALTH Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to July 6, 1921, that I last saw h[illegible] alive on July 6, 1921, and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydro nephrosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of June 24

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological

(Signed) [illegible] M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL July 9 1921

20 UNDERTAKER Milland B Callender

ADDRESS Bank & Ann Sts

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55206

CERTIFICATE OF DEATH.

104 D 55206

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 S. Vincent ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charley Sherman

(Residence in Baltimore: No. 309 S. Vincent St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, May (Month) 29 (Day), 1921 (Year)

7-AGE, ... yrs. 1 mos. 8 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... gods

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Robert E. Staples

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Alice Cossman

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert E. Staples

(Address) 309 S. Vincent st

15- JUL 8 1921 ROBERT J. [illegible]

Filed ....., 191... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1921, to July 7 1921, that I saw h[illegible] alive on July 6 1921, and that death occurred, on the date stated above, at 11:50 A m.

The CAUSE OF DEATH* was as follows:

Otis Calitis

..... (Duration) ..... yrs. ..... mos. 26 ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Bayrau M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 37 ds. In the State ..... yrs. ..... mos. 37 ds.

Where was disease contracted, if not at place of death? 309 S Vincent St.

Former or usual residence 309 S. Vincent St.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, July 9th, 1921

20-UNDERTAKER A. Jones ADDRESS 207 S. Stricker st

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55207

D 55207

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 Parsish ST. 16 WARD)

2-FULL NAME Eleanora Jackson Griffin

(a) RESIDENCE. NO. 1133 Parrish ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Wm Griffin

6 DATE OF BIRTH (month, day, and year) Mar 22-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 83

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS

10 NAME OF FATHER Andrew Jackson

11 BIRTHPLACE OF FATHER (city or town) Danesville (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Elizabeth Fleming

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Virginia

14 Informant Wm Griffin (Address) 1133 Parrish St.

15 JUL 8 1921 ROBERT I. CRAWFORD Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 22, 19 21, to July 5, 19 21

that I last saw h alive on July 5, 19 21

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Z13. Sputum

(Signed) Chas E Brown, M. D.

7 6 1921 (Address) 1837 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 8 1921

20 UNDERTAKER Edw. Ruggold ADDRESS 1463 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55208

CERTIFICATE OF DEATH.

D 55208

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tbc Hosp (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Griffin

(a) RESIDENCE. NO. 741 Gay Alley ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): M

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Nathan Griffin

6 DATE OF BIRTH (month, day, and year) April 1 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

070

9 BIRTHPLACE (city or town) (State or country): Leomey Va

PARENTS

10 NAME OF FATHER: Thos Hause

11 BIRTHPLACE OF FATHER (city or town) (State or country): ~~Va~~

12 MAIDEN NAME OF MOTHER: Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ~~Va~~

14 Informant: Hospital Records

(Address) ~~1831 E. Chase~~

15 Filed JUL 8 1921 16 Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5th 3:30 PM. 1921, to July 5th 6 PM. 1921, that I last saw h~~im~~er alive on July 5th 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis L Donaghue, M. D.

, 19 (Address) Municipal Tbc Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1921

JUL 8

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55209

CERTIFICATE OF DEATH.

D 55209

1-PLACE OF DEATH St. Agnes Hosp. 108 REGISTERED NO.

CITY OF BALTIMORE: (No. 25 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonidas Peddicord.

(a) RESIDENCE. No. Ellicott City. Maryland Ave WARD. Ellicott City

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Hospital Records. (Address)

15 Filed JUL 8 1921 ROBERT I. BRUTER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1921, to July 7, 1921, that I last saw him alive on July 7, 1921, and that death occurred, on the date stated above, at 9 20 P. m.

The CAUSE OF DEATH* was as follows:

1) Ruptured appendix.
2) Peritonitis.

(duration) — yrs. — mos. 5 da

CONTRIBUTORY (Secondary) Myocardial insuff. chr. nephritis (duration) — yrs. — mos. 2 wks

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-7-21.

Was there an autopsy? No

What test confirmed diagnosis? Cultures & smears.

(Signed) Dudley P. Bowe, M. D.

19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Johns Cemetery	July 10 1921
20 UNDERTAKER Eastern Sons	ADDRESS Ellicott City Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55210

CERTIFICATE OF DEATH.

40 D 55210

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 319 N. Hoffman ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Augustus

(a) RESIDENCE. No. 319 N. Hoffman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua Augustus

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56 Yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. 21

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer ?.

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Jos Hollis

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Amelia Pindell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Ella Scott
(Address) 319 N. Hoffman st

15 JUL 8-1921 ROBERT E. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to July 6, 1921, that I last saw h.W alive on July 6, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward J. Wheeler, M. D.

7/8, 1921 (Address) 1238 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cmty	7/10 1921
20 UNDERTAKER J. Frow Hall	ADDRESS 1741 D Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55211

CERTIFICATE OF DEATH.

IV D 55211

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerby K. Ditchett.

(a) RESIDENCE. NO. 3133 N. Calvert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	-	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Linde Thread Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Wm J. Ditchett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Helen R. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Mrs Helen R. Ditchett. 2135 Bolton St

15 Filed JUL 8-1921 ROBERT I. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27th 1921 to July 7th 1921 that I last saw h[illegible] alive on July 7th 1921 and that death occurred, on the date stated above, at 10.50 P.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) - yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Perforation: Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 7/1/21

Was there an autopsy? No.

What test confirmed diagnosis? Phys. Examination

(Signed) Fred L. Blanchard M. D.

7/7 1921 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	July 9-21
20 UNDERTAKER: Wilson & Foster	ADDRESS 1223 N. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55212

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1443 E Eager St.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M Patterson

(a) RESIDENCE. No. 1443 E Eager St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Charles W Patterson

6 DATE OF BIRTH (month, day, and year) April 20th 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 001

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John D. McCoubrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eliza A James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Annie E Schaefer 2420 Maryland Ave

15 Filed JUL 8 - 1921, 19 ROBERT J. CARTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27th, 19 21, to July 7th, 19 21,

that I last saw h[illegible] alive on July 7th, 19 21

and that death occurred, on the date stated above, at 6.35 P.m.

The CAUSE OF DEATH* was as follows:

A Stric[illegible] of Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

July 9, 19 21 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	July 9th 1921
20 UNDERTAKER	ADDRESS
Geo. J. Dillon & Sons	1126 E Monument

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 55213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 55213

REGISTERED NO.

1-PLACE OF DEATH Latrobe Apt

CITY OF BALTIMORE: NO. Charles & Read ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lennie Snowden Lanahan

(a) RESIDENCE. NO. Charles & Read ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Late Charles M. Lanahan

6 DATE OF BIRTH (month, day, and year) May 25 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Richard Snowden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Martha Seaman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs. Charles M. Lanahan
(Address) Illinois Ind

15 Filed JUL 8 - 1921 ROBERT J. KRAUTH Registrar
Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 . 1921 . to July 7 . 1921 . that I last saw h[illegible] alive on July 7 . 1921 . and that death occurred, on the date stated above, at 9 15 A.M.

The CAUSE OF DEATH* was as follows:

Uremia Nephritis

(duration) Rural yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic, stenosis & insufficiency (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) Ed Lathbart M. D.

. 19 (Address) 1006 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 9 1921
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Son	Eutaw & Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 79 D 55214

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Johnson.

(Residence in Baltimore: No. 3812 Lester St Richmond, Va. St.: yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH. Do not know. (Month), / (Day), ... (Year)

7-AGE. 32 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seaman S/S West
(b) General nature of industry, business, or establishment in which employed (or employer): Lashaway.

9-BIRTHPLACE. (State or Country), Richmond, Va.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Capt. John O. Farrow.

(Address) 320 Main St. Soco, Me.

15- Filed JUL 8-1921, 191.... ROBERT I. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7th. 1921. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Oedema of the lungs.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

July 8. 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? S/S West Lashaway, Pier 5 Locust Pt.

Former or usual residence Richmond, Va.

19-PLACE OF BURIAL OR REMOVAL, Richmond Va — DATE OF BURIAL, July 9. 1921

20-UNDERTAKER John F. Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Eks.

149225 D 55215

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

137 D 55215

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. John Hopkins Hospital (ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Shorter.

(a) RESIDENCE. No. 436 N. Register St. (Balto Md. 1 ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Shorter (Husband)

6 DATE OF BIRTH (month, day, and year): April 8,

7 AGE: Years: 27 Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer): Homemaker

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): St Marys Co in Balt 12 years

PARENTS

10 NAME OF FATHER: John Chesley.

11 BIRTHPLACE OF FATHER (city or town): ? (State or country): Unknown ?

12 MAIDEN NAME OF MOTHER: Mary Shaw Chesley

13 BIRTHPLACE OF MOTHER (city or town): ? (State or country): St Marys Co Md.

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed ....., 19.... JUL 9 - 1921 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1921, to July 6, 1921, that I last saw her alive on July 6, 1921, and that death occurred, on the date stated above, at 7:50 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Guy W. Thomazell, M. D.

7/7, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: July 9 1921

20 UNDERTAKER: Mrs R A Elliott

ADDRESS 1725 Ashland Ave

(over)

TION is very important. See instructions on back of certificates.

D 55216

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH S/S Lake Fanquier. 1917 REGISTERED NO. C.....

CITY OF BALTIMORE (No. South end of Andre St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl E.G. Anderson.

(Residence in Baltimore: No. Unknown. St.: 1 yrs., ---- mos. ---- ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, April 1st., 1897., / (Month) (Day) (Year)

7-AGE, 24 yrs. 2 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 032

9-BIRTHPLACE, (State or Country), Sweden.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Capt. Gustav Otter.....

(Address).....700 Belair Road.....

15-

Filed JUL 9 1921, 191.... G.H. Gross Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) & inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally electrocuted
on S/S Lake Fanquier.
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

July, 7..., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
PUBLIC CEMETERY.	....., 19....
20-UNDERTAKER Commissioner Health.	ADDRESS

WOODALL

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55217

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 N. Poppleton ST.; 18 WARD)

2-FULL NAME Florence M. Blum

(a) RESIDENCE. NO. 1811 Poppleton ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 20/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank Blum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ellen Wadsworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Florence M. Blum

(Address) 1811 Poppleton St.

15 JUL 9-1921 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1921, to July 8, 1921, that I last saw h alive on July 5, 1921, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) M. K. Campbell M. D.

July 8, 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	July 9 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55218 HEALTH DEPARTMENT—CITY OF BALTIMORE D) 55218

CERTIFICATE OF DEATH.

+ 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Bucker

(a) RESIDENCE. No. ..... ST., ... WARD. Laurel Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE 30 Years — Months — Days. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(n) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant ..... (Address)

15 July 9 1921 19 G. H. Gresh Registrar

St Joseph Hospital

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1921, to July 8, 1921, that I last saw h.e.r. alive on July 8, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

..... (duration) Unknown mos.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? P. S. & S. Laboratory

(Signed) Frank C. Marino M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel, Md. DATE OF BURIAL: July 9 1921

20 UNDERTAKER: John J. Dailey & Sons ADDRESS: 1318 Light

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55219

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 N. Curley ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward F. Bauer

(a) RESIDENCE. No. 425 N. Curley ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Divorced

6 DATE OF BIRTH (month, day, and year): Sept 13/1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cooper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John B. Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Anna M. Bittrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mrs. John Foster

(Address): 425 N. Curley St

Filed JUL 9-1921

G. H. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1921, to July 7, 1921, that I last saw him alive on July 6, 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Pulmonia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Greer, M. D.

7/9, 1921 (Address) 2600 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 11 1921

20 UNDERTAKER: W. J. Ihm ADDRESS: 156 N. Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55220

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 D 55220

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 708 Gorsuch ave ST.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mabel Bardnell Frink

(Residence in Baltimore: No. 708 Gorsuch Ave St.: 84 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: April (Month) 26 (Day), 1837 (Year)

7 AGE: 84 yrs. 2 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Living at home
(b) General nature of industry, business, or establishment in which employed (or employer): 0 0 0

9 BIRTHPLACE (State or country): S. Hadley Falls Massachusetts

PARENTS

10 NAME OF FATHER: Alonza Bardnell

11 BIRTHPLACE OF FATHER (State or country): Massachusetts

12 MAIDEN NAME OF MOTHER: Harriet White

13 BIRTHPLACE OF MOTHER (State or country): Massachusetts

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. S. Parkhurst

(Address) 1410 Park Ave

15 JUL 9 - 1921 191 G. H. Gr[illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 7 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1911, to July 1921
that I saw her alive on July 7th, 1921.
and that death occurred, on the date stated above, at 11.30 a m.
The CAUSE OF DEATH* was as follows:

Epithelioma of face
& head

(Duration) 10 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Alice S. Parkhurst M. D.

July, 1921 (Address) 1410 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Park Cem | DATE OF BURIAL: July 9 1921

20 UNDERTAKER: John A Mitchell | ADDRESS: 201 N. Fayette

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55221

CERTIFICATE OF DEATH.

104 D 55221

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 803 N. Dallas St ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Wm Hanson

(a) RESIDENCE NO. 1303 N Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 20 1920

7 AGE: Years 1 Months 0 Days 19

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) — Balto

PARENTS

10 NAME OF FATHER Frdk. C. Hanson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Kastner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mary Hanson (Address) 1303 N Dallas

15 Filed JUL 8 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1921, to July 8, 1921, that I last saw him alive on July 8, 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis & Nephritis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Unk

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jacob Fushan M. D.

7/8. 1921 (Address) 1823 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: July 11 1921

20 UNDERTAKER: Wm Corbin — ADDRESS: 1419 N.L.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55222 — D 55222

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2039 E Lanvale St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll A Williams

(a) RESIDENCE. No. 2039 E Lanvale St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 2 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie E Williams

6 DATE OF BIRTH (month, day, and year): July 22 1897

7 AGE: Years 24 Months 11 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George F Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Alice L Dyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

11 Informant: Alice L Williams (Address) 2039 E Lanvale St

15 Filed JUL 9-1921, 19 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1921

I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to July 8, 1921, that I last saw him alive on July 8, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac dilatation 4 hrs

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Brailey King Cor M. D.

7/8, 1924 (Address) 2027 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden — DATE OF BURIAL: July 11 1924

20 UNDERTAKER: Wilhelm Bros — ADDRESS: 502 E Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

25 104 D 55223

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 37 Mason St. Masonville. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert W. Arnold.

(Residence in Baltimore: No. 37 Mason St. Masonville. St.; yrs., 2 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH. April 18th, 1921., 1 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
------ yrs. 2 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work.... None.
(b) General nature of industry, business, or establishment in which employed (or employer)....

9-BIRTHPLACE. (State or Country). Masonville

PARENTS.

10-NAME OF FATHER. Robert M. Arnold.

11-BIRTHPLACE OF FATHER (State or Country). Fairfield.

12-MAIDEN NAME OF MOTHER Julia Gray.

13-BIRTHPLACE OF MOTHER (State or Country). Fairfield.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Arnold. (mother)

(Address) 37 Mason St. Masonville.

15- G. H. Crose.

Filed JUL 9-1921, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 8th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea and Enteritis.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

July 8., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill	July 9., 1921
20-UNDERTAKER	ADDRESS
Geo. L. Schwab & Bro	210 E. Fayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55224

CERTIFICATE OF DEATH.

D ~~55224~~

264

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 Gough St - St.; 2 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A J. Male

(a) RESIDENCE. No. 1836 Gough St - St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin F. Male

6 DATE OF BIRTH (month, day, and year) May 12 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cornelia Manly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Benjamin F. Male

(Address) 1836 Gough St -

15 Filed ..., 19... Registrar

JUL 8 — 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1921, to July 8, 1921, that I last saw h[illegible] alive on July 8, 1921, and that death occurred, on the date stated above, at 11 55 a m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A L Tomlinson, M. D.

7/8. 1921 (Address) 2013 Banks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn.	July 11 1921

20 UNDERTAKER H. W. Cook

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF DYING is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

55225 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 55225

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 Madison Ave ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Chas. & Ruth Shipley

(a) RESIDENCE. NO. 708 Madison Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1/4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8/21

7 AGE	Years	Months	Days	If LESS than 1 day 10 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 0ds

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas R. Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas R Shipley
(Address) 708 Madison av

15 Filed JUL 8 - 1921 . 19 C. H. Gross, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1921, to July 8, 1921, that I last saw h[illegible] alive on July 8, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Failure of Circulation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Failure of Foramen Ovale to Close

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H S McCard M. D

7/9, 1921 (Address) 2005 Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	July 9 1921
20 UNDERTAKER Short & Holland	ADDRESS 163 Howard Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55226

CERTIFICATE OF DEATH.

64 D 55226

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 511 East of 424 Albert ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophie Jackson

(Residence in Baltimore: No. National St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. Unknown ..... (Month) ..... (Day) 1 (Year)

7-AGE. 62 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eastern Police Station

(Address) Bank St

15-

Filed ..... 191.....

G. H. Cresse
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Death after paralysis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Fehl Coroner M. D.
(Coroner)
7/7, 1921. (Address) 500 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL JUL 9 1921, 19..

20-UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND

55227

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55227

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Blue Pond Lansdale's Rd, ST. 25 WARD) REGISTERED No. C 169

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Turner

(Residence in Baltimore: No. 5 Cedar St West Pat St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Mar'd

6-DATE OF BIRTH, Sept 26, 1904 (Month) (Day) (Year)

7-AGE, 16 yrs. 9 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Helper Gr
(b) General nature of industry, business, or establishment in which employed (or employer)..... Edw Blover

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John T Turner

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Kat Sadler

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary K Turner

(Address) 5 Cedar St.

15-

Filed JUL 9-1921 G. H. Giese

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning

(Duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Boulton M. D. (Coroner)

July 8, 1921 (Address) 701 E Chase St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	July 9, 1921
20-UNDERTAKER	ADDRESS
E Fleming & Son	1538 E Lafayette

N. B.—Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

~~Dec~~ 55228

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 55228

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincent Asyl ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Males

(a) RESIDENCE. No. St Vincent Asy's ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md

PARENTS

10 NAME OF FATHER Dec Muzzy

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant St Vincents Asy
(Address) 600 Dunn

15 Filed JUL 9 - 1921 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) July 9 1921

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1921, to July 8, 1921, that I last saw h.m alive on July 8, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Mes Colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Mes Prostatis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas Heberton M. D.

July 9 1921 (Address) 1504 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents cemetery	July 10 1921

20 UNDERTAKER Edmond Jamison ADDRESS 1318 Light St

mation should be carefully supplied. AGE should be stated
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 55229

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10

D 55229

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 Kirk ct ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Kane

(a) RESIDENCE NO. 722 Kirk ct ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year)

7 AGE 40 Years — Months — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 37

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) born in Baltimore (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant John Kane (Address) 722 Kirk Court

15 Filed JUL 9 1921 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5 1921 to Jan 9 1921, that I last saw h alive on July 8 1921, and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(duration) yrs. 1 mos dys

CONTRIBUTORY (Secondary) Contributory

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy M. D.

1/9/21 19 (Address) 1075 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL July 9 1921

20 UNDERTAKER Jones R A Ellis

ADDRESS 1725 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55238 HEALTH DEPARTMENT—CITY OF BALTIMORE 552330

D 55238 CERTIFICATE OF DEATH. 104 D 55230

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 S. Parrish ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ada May Covell

(Residence in Baltimore: No. 440 S Parrish St.; ....yrs. 10 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, July (Month) 8 (Day), 1921 (Year)

7-AGE, ...yrs. 10 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, William H Covell.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Addie M. Collins

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Covell

(Address) 440 S. Parrish st.

15- Filed JUL 10 1921 191.... G. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 4 1921, to July 8 1921, that I saw her alive on July 7 1921, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Cholera Infantorum

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Joseph E. Muse M. D.

July 8, 1921 (Address) 1521 C Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, July 12th 1921

20-UNDERTAKER A. Jones ADDRESS 207 S. Strucker St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

D 55231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55231

CERTIFICATE OF DEATH.

July 9-041

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; 4 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Nellie Burger

(a) RESIDENCE. NO. 205 N. Fremont St., ... Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, (Widowed,) or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Isaac Byron.

11 BIRTHPLACE OF FATHER (city or town) Pa (State or country)

12 MAIDEN NAME OF MOTHER Anne Conrad

13 BIRTHPLACE OF MOTHER (city or town) Penna (State or country)

14 Informant University Hospital (Address)

15 JUL 10 1921 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1921, to July 9, 1921.

that I last saw h e alive on July 8, 1921.

and that death occurred, on the date stated above, at 3.45 am. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Mitral regurgitation, myocardial insufficiency (duration) 6. yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Physical examination

(Signed) J K B Jones, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md	July 11 1921
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	Hagerstown

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55232

CERTIFICATE OF DEATH.

D 55232

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 2315 Harlem av ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J Clocker

(Residence in Baltimore: No. 2315 Harlem av St.; 65 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH. Nov 18, 1842 (Month) (Day) (Year)

7-AGE. 79 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Ellicott City Md

PARENTS.

10-NAME OF FATHER, Thos. S. Lister

11-BIRTHPLACE OF FATHER (State or Country), Phil. Pa.

12-MAIDEN NAME OF MOTHER Elizabeth Sunderland

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J. B. McCahan Jr.

(Address) 2315 Harlem Av

15- Filed JUL 10 1921, 191 G. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9, 1912 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 20 1911, to July 9 1912, that I saw h-- alive on July 7 1912, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows: Carcinoma of bladder & Ulcer

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ex Cancer of Lead

(Duration) yrs. mos. ds.

(Signed) John H. Dean M. D.

July 9 1912 (Address) 101 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, July 1., 1912

20-UNDERTAKER George J. Smith ADDRESS 1000 N Eutaw St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FRACTIONS of months should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55233

CERTIFICATE OF DEATH.

5 38

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Franklin Square Hosp ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annetta Pappalardo

(a) RESIDENCE. NO. 368 Forest ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Domenico Pappalardo

6 DATE OF BIRTH (month, day, and year) Feb 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Samuel Palmicon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Domenico Pappalardo (Address) 368 Forest St.

15 Filed JUL 10 1921 19 C. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2 . 1921, to July 8 . 1921, that I last saw h e alive on July 8, 1921, and that death occurred, on the date stated above, at 5 25 P m.

The CAUSE OF DEATH* was as follows:

Utero-vaginal fistula operation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis & shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July-7-21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard M. Bulbert, M. D.

(Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents Cemetery	July 10 1921
20 UNDERTAKER Harry H. Nitzke	ADDRESS 153 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., *of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Example: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to
Chr. Gonococcus Infection

...—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55234

CERTIFICATE OF DEATH.

D 55234

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 A Washington St.: 8 91 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Centon Sladek

(a) RESIDENCE. NO. 1417 A Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Centon Sladek

6 DATE OF BIRTH (month, day, and year) Oct 6 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	59	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cobler 83

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Sladek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Centon Sladek 1417 A Washington St

15 Filed JUL 10 1921, 19... C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1921, to July 8, 1921, that I last saw h... alive on July 8, 1921, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

acute Mania & Anemia 4 ds.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? findings

(Signed) J. M. ... M. D.

(Address) 1001 Bull Pier St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 11 1921
20 UNDERTAKER	ADDRESS
Fred Graf Son	1906 Eastern Ave

* CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55235

CERTIFICATE OF DEATH.

91 D 55235

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 E Madison ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonie Nemec

(a) RESIDENCE. NO. 2118 E Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Nemec

6 DATE OF BIRTH (month, day, and year) Abt 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Joseph Nemec (Address) 2118 E Madison St

15 Filed ....., 19.... JUL 10 1921 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1921, to July 9, 1921, that I last saw h[illegible] alive on July 9, 1921, and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

12 [illegible] 1921 (Address) 800 N Bethesda

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 13 1921
20 UNDERTAKER Frank Enoch & Son	ADDRESS [illegible] Garrison Blvd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55236 — 55236

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 759 Bradley ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Archie Lucas

(a) RESIDENCE. No. 759 Bradley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/25/85

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) Transfer

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mable Lucas (Address) 759 Bradley

15 Filed JUL 10 1921 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8/1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1920, to July 8, 1921, that I last saw him alive on July 8, 1921, and that death occurred, on the date stated above, at 11.15 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. 0 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. F. Roberts, M. D.

July 10, 1921 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 10 1921
20 UNDERTAKER	ADDRESS 916
David Tipton	Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55237

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55237

CERTIFICATE OF DEATH.

24 169

(PLACE OF DEATH

CITY OF BALTIMORE (No Off 500 foot span Hanover St. Bridge WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-FULL NAME John Janiszewski.

(Residence in Baltimore: No. 1530 William St. St.: 12 yrs., 1 mos., -- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, June 8th, 1909., 1 (Month) (Day) (Year)

7-AGE, 12 yrs. 1 mos. ------ ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Janiszewski.

11-BIRTHPLACE OF FATHER (State or Country). Poland.

12-MAIDEN NAME OF MOTHER Frances Knoblok.

13-BIRTHPLACE OF MOTHER (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Janiszewski. (father)

(Address) 1530 William St.

15- Filed JUL 1 0 1921 191.... G. H. Grese Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 8th, 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Rembach M. D. (Coroner)

July 9., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary. DATE OF BURIAL, July 10., 1921

20-UNDERTAKER Wm Fialkowski ADDRESS 618 Eastern Ave

P. S. Certificate should be filled out carefully, applying. All items must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 55238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55238

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Sch Stephen Chase Balto Harbor ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt. J. Lee

(Residence in Baltimore: No. Non Resident St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 30 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sailor
(b) General nature of industry, business, or establishment in which employed (or employer): Sailor

9-BIRTHPLACE, (State or Country). No Residence in Balt- North Cumberland Co Va

PARENTS.

10-NAME OF FATHER, Robert James Lee

11-BIRTHPLACE OF FATHER (State or Country) North Cumberland Co Va

12-MAIDEN NAME OF MOTHER Bettie Sidney

13-BIRTHPLACE OF MOTHER (State or Country). Thumber Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Birthia Slaham
(Address) 15-20 E Madison St

15-
Filed JUL 10 1921, 191.... G. H. Gross Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide
Fracture of skull, 1st
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Drowning
(Duration) yrs. mos. ds.

(Signed) J. C. Gladden M. D.
(Coroner.)
July 8th 1921 (Address) 143 Hoen

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (a) MEANS OF INJURY; and (a) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs.....mos.....ds. In the State ....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, July 10, 1921

20-UNDERTAKER Chas R A Elliott — ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

55239 55239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 552 D 552

CERTIFICATE OF DEATH.

14 91 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 532 Laurens ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Smith

(Residence in Baltimore: No. 532 Laurens St.: yrs., 9 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Oct. 6, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Morris Smith

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER Eugenia Shipley

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugenia Smith

(Address) 532 Laurens St.

15- G. H. Grese.

Filed JUL 10 1921 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inq. (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. 9 mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Heemsbergh M. D.

(Corner.) July 9. 1921 (Address) 2802 Eastmoreland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Laurel Cem. DATE OF BURIAL, July 12 a. 1921

20-UNDERTAKER Sam'l F. Chase Son ADDRESS 1400 Mosher

I. B. Every item must be answered. If unknown or the answer is doubtful, say so. Do not leave blanks. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓

C 55240

CERTIFICATE OF DEATH.

151 D 55240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 W. Hamburg ST.; 22d WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irving Adams Jr.

(Residence in Baltimore: No. 18 W. Hamburg St.; — yrs., — mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 25th (Day), 1921 (Year)

7-AGE, ...yrs. ...mos. 14 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Irving T. Adams

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Grace V. Fields

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irving T. Adams

(Address) 18 W. Hamburg St.

15-

Filed JUL 10 1921, 191... C. H. Cross Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 9th (Day), 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from July 6th 1921, to July 9th 1921, that I saw h~~im~~ alive on July 9th 1921, and that death occurred, on the date stated above, at 9:45 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) Harry Kleibel M. D.

7/10/21 1921. (Address) 1224 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	July 11, 1921
20-UNDERTAKER	ADDRESS
Schumacher & Son	Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

55241 Grese

D ~~55239~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

55241

D ~~55239~~

CERTIFICATE OF DEATH.

167

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Josephs Hospital WARD) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Schmidt

(Residence in Baltimore: No. 828 S. Pratt. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Bach.

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 3 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Adam Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Julia Harrington

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Adam Schmidt

(Address) 828 E. Pratt St.

15-

Filed ..... 191.....

JUL 10 1921

C. H. Grese
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Died from Operation for Stone in Kidney

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Burns

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) D.

7-10, 1921 (Address) 7 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cem.

DATE OF BURIAL. July 11, 19 21

20-UNDERTAKER Wendell Dippel & Son

ADDRESS 37 E. Lanvale St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55242

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 N 24 St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geneva Boynes

(Residence in Baltimore: No. 203 N 24 St. Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE, ... yrs. 8 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 0
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Russell Boynes

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Miller

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Russell Boynes

(Address) 203 N 24

15- G. H. Grese.

Filed JUL 10 1921 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2d, 1921, to July 9th, 1921, that I saw her alive on July 8th, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Diarrhea and
Heart

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) 9 yrs. ..... mos. ..... ds.

(Signed) W. H. Pearce M. D.

July 10, 1921. (Address) 2405 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	July 13 1921
20-UNDERTAKER	ADDRESS
David T. Hennelly	1778 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55243

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5811 Bellona Ave ST.: 27 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Steinecke

(a) RESIDENCE. No. 5811 Bellona Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Steinecke

6 DATE OF BIRTH (month, day, and year) 1841 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John. Stoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Geo. Steinecke

(Address) 5811 Bellona Ave

15 Filed JUL 10 1921, 19..

G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1916, to July 7 1921, that I last saw h[illegible] alive on July 7 1921, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ½ hr ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hess, M. D.

7-8, 1921 (Address) 5600 York Rd Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govans Presbyterian Cem,	July 10 " 1921
20 UNDERTAKER	ADDRESS
John J. Gowan & Son	901 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55244 D 55244

CERTIFICATE OF DEATH.

REGISTERED NO. 1451

1-PLACE OF DEATH

CITY OF BALTIMORE (No. N43 Argyle ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Wilhelmina Roedern

(a) RESIDENCE. NO. N43 Argyle ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Roedern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada B.W.I.

12 MAIDEN NAME OF MOTHER M. W. Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn N.Y.

14 Informant (Wilhelmina Roedern)
(Address) N43 Argyle ave

15 Filed ..... 19 .....
Registrar

JUL 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 July 1921

17 I HEREBY CERTIFY, That I attended deceased from 3 July 1921 to 3 July 1921

that I last saw h[illegible] alive on 3 July 1921

and that death occurred, on the date stated above, at 11.30 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No where.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Mayfield Taylor M. D.

1924 (Address) 1427 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: July 11 1921

20 UNDERTAKER: Jos. M. Johnson

ADDRESS 23 Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

...ec.—6-9-19—H. P. Co.—1000 Bks.

D 55245

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 55245

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 W. Sanvale ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George G. Everhart

(a) RESIDENCE. No. 1616 W. Sanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. ds. How long in U. S., if of foreign birth? 90 yrs. 6 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 1st 1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister of the Gospel.

(b) General nature of industry, business, or establishment in which employed (or employer) — 018

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Manchester, Md.

PARENTS

10 NAME OF FATHER David Everhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Manchester, Md.

12 MAIDEN NAME OF MOTHER Nancy Hoke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York, Pa.

14 Informant Mrs. Chas. L. Lebow
(Address) 1916 Mt. Royal Ter.

15 Filed JUL 10 1921 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921 to July 8, 1921 that I last saw him alive on July 8, 1921 and that death occurred, on the date stated above, at 12.20 a.m.

The CAUSE OF DEATH* was as follows:

Infirmaties of Age.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostration due to Excession Hot weather

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. M. Barnebaker, M. D.

, 19 (Address) 120 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	July 11 192
20 UNDERTAKER	ADDRESS
Stewart Memorial Co. (E. J. Worden)	108 N. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55246

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55246

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 739 N. Patterson Park Ave (STREET OR AVE.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loretto Flaherty

(a) RESIDENCE. NO. 739 N. Patterson Park Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 24. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	5	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Peter Flaherty

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary H. Collins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Wm. Leo. Flaherty
(Address) 739 Patterson Park Ave

15 Filed JUL 10 1921, 19 C. H. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 - 1920

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1920, to July 7, 1920,
that I last saw h 27 alive on July 7, 1920
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. - mos. - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sguibb, M. D.

(Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral bm	7/11/1921
20 UNDERTAKER J. J. Moran	ADDRESS 300 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55247

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 ✓

CERTIFICATE OF DEATH.

D 55247

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1404 N. Gay ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Bradley

(a) RESIDENCE. NO. 1404 N. Gay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 000

(b) General nature of Industry, business, or establishment in which employed (or employer) ... Howard County Md

(c) Name of employer ... U. S.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph C. Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Adalaide Gernhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Adalaide Gernhart
(Address) 1404 N. Gay St

15 Filed JUL 11 1921 19 ...
JUL 11 1921
Registrar C. H. Cross.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 7, 19 21, to July 10, 19 21,
that I last saw h. alive on July 7, 19 21,
and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6½ mos. Pregnancy
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) J. H. Cochran, M. D.

19 (Address) 300 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn — DATE OF BURIAL: July 11 1921

20 UNDERTAKER: Zirkler & Zirkler — ADDRESS: 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55248

CERTIFICATE OF DEATH.

1792 D 55248

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood Sanitarium ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cynthia Anne Benham

(a) RESIDENCE. No. The Cecil, N. Eutaw ST., 11th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: DeWitt Clinton Benham

6 DATE OF BIRTH (month, day, and year): Mar. 29, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	3	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lady at Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Wyckoff New York, U.S.A.

PARENTS

10 NAME OF FATHER: David Arne

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Mary Monroe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Elridge N.Y. New York

14 Informant (Address): DeWitt W. Benham The Cecil, Baltimore, Md

15 Filed JUL 11 1921 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8 1921 to July 9 1921, that I last saw her alive on July 9 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Excessive heat

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J. Hratton, M. D.

July 11. 1921 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Beaver Pa.	July 11th 1921
20 UNDERTAKER: Kenny W Jenkins & Sons	ADDRESS: 111 Eutaw Pl Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55249

CERTIFICATE OF DEATH.

D 55249

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 323 N. Fremont ST. 22 WARD) 104

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Ennis

(Residence in Baltimore: No. 323 N. Fremont St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colrd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sngle

6-DATE OF BIRTH, Dont Know, 1 .....
(Month) (Day) (Year)

7-AGE, 1 yrs. 3 mos. ..... da.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Bath Md

PARENTS.

10-NAME OF FATHER, Herman Ennis

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER John Clayton

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Clayton

(Address) 323 N Fremont Ave.

15- JUL 11 1921. 191 ..... G. H. Gross
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, au- topsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis acute

..... (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Heart & Lung

..... (Duration) ..... yrs. ..... mos. 3 da.

(Signed) W K Gorman M. D.
(Coroner)

7-11-, 1921 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Md Auburn Cem — DATE OF BURIAL, July 11, 1921

20-UNDERTAKER Daniel Easton — ADDRESS 916 Penna Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55250

CERTIFICATE OF DEATH.

15 / 120

D 55250

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 Liberty Heights Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nettie Lemmon Johnson

(Residence in Baltimore: No. 2914 Liberty Heights Avenue St.; ....yrs. 2 mos. 9 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, Feb (Month) 2 (Day), 1846 (Year)

7-AGE, 75 yrs. 5 mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Harrisonburg Va

PARENTS.

10-NAME OF FATHER. James R Harrold

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Margaret Bryan

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret C. Gaeng

(Address) 2824 Guilford Ave

15-

Filed JUL 11 1921 191.....

G. H. Grier
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 25 1921, to July 9th 1921, that I saw h[illegible] alive on July 8 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(Duration) ....yrs. ....mos. 16 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. D. Hammond M. D.

July 9th, 1921 (Address) 1224 Edmondson ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 10 mos. 9 ds. In the State 26 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 2914 Liberty Heights Avenue

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem

DATE OF BURIAL, July 12 1921

20-UNDERTAKER Jos Joerdens Son

ADDRESS 217 S. Paca

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55251

CERTIFICATE OF DEATH.

D 55251

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3706 Old York Road ST.: 9 WARD) 115

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William James Gillingham

(a) RESIDENCE. No. 3706 Old York Road ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Gillingham

6 DATE OF BIRTH (month, day, and year) January 18th 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	0	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Lee H Gillingham

(Address) 3906 Old York Road

15 Filed JUL 11 1921 19 G. H. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1921

17

I HEREBY CERTIFY, That I attended deceased from [illegible] 1921, to July 9th 1921,

that I last saw h[illegible] alive on July 7th 1921

and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

a Cerebral Hemorrhage

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

7/9. 1921 (Address) 4816 45th Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
BALTIMORE CEMETARY.	JUL // 1921
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	716 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

55252

HEALTH DEPARTMENT—CITY OF BALTIMORE

55252

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 N Carey ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Frederick Schultz

(a) RESIDENCE. NO. 433 N. Carey. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred —yrs. 18 mos. —ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 - 1900

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
21		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sign painter

(b) General nature of industry, business, or establishment in which employed (or employer) Do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Pearl Bradbinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Michigan

14 Informant Pearl Schultz
(Address) 433 N. Carey Balt.

15 Filed JUL 11 1921 G. H. Crese Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st 1921 to July 9 1921.

that I last saw him alive on July 9 1921.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) T. Allen Hemming M.D.

7/10 1921 (Address) 2000 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friendship Cem	July 11 21
UNDERTAKER Hoss	ADDRESS Fickus Home Notts & Penn

D 55253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55253

1847

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Md. Gen. Hosp ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Reed

(Residence in Baltimore: No. 1806 Ashburton St. St.: 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, Aug. 1, 1857
(Month) (Day) (Year)

7-AGE, 63 yrs. 11 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mariner & Watchman
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm. Reed

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary E. Reed

(Address) 1806 Ashburton St.

15-

JUL 11 1921 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said us (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
Homicidal
(Duration) yrs. mos. 12 hrs ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

July 10, 1921 (Address) 2802 Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place Md. Gen. Hosp In the of death yrs. mos. 1 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? Howard & Park Ave

Former or usual residence 1806 Ashburton St

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery

DATE OF BURIAL, July 11 1921

20-UNDERTAKER Wm. Tuckers Sons

ADDRESS North & Paca

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55254 Grose

1794

REGISTERED NO. C 55254

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 N. Chas. St. ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Kate Hurlock

(Residence in Baltimore: No. No 1315 N. Chas St St.; — yrs., — mos. 9 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	widow

6-DATE OF BIRTH, Apr (Month) 6 (Day), 1852 (Year)

7-AGE, 69 yrs. 3 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Centreville, Md

PARENTS.

10-NAME OF FATHER, John A. Evans

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER Martha Harwood

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. N. Lisco

(Address) 1315 N. Chas. St

15-

Filed JUL 11 1921 G. H. Grose Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 10 1921, that I saw her alive on July 10 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. N. Lisco M. D.

July 10, 1921. (Address) 1315 N. Chas. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 9 ds. In the State 69 yrs. 3 mos. 4 ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Chestertown, Md.

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL.
Chestertown Md	July 11, 1921

20-UNDERTAKER Wm. Lucas & Son ADDRESS Norfolk

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55255

CERTIFICATE OF DEATH.

40

REGISTERED No. C D 55255

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Gorsuch av ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John B. Connolly

(Residence in Baltimore: No. 701 Gorsuch av St.; 58 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, May 14th (Month) (Day), 1862 (Year)

7-AGE, 59 yrs. 1 mos. 24 ds. If LESS than 1 day, 3 hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Locomotive Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Pennsylvania R.R. Co

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, John B. Connolly

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Maryland

12-MAIDEN NAME OF MOTHER Mary M. Mullen

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lawrence J. Connolly

(Address) 409 Marleland Ave.

15-

Filed JUL 11 1921 G. H. Crese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to July 8 1921, that I saw h[illegible] alive on July 8 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. Strickler Jr. M. D.

July 9, 1921 (Address) 632 Gorsuch av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
F. Mays — Irvington	July 12, 1921

20-UNDERTAKER J. J. Lee & Son ADDRESS 1424 Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.--6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55256

CERTIFICATE OF DEATH.

D 55256

REGISTERED NO. 6 1132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 N. Robinson ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Hahn

(a) RESIDENCE. NO. 433 N. Robinson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Caroline Hahn

6 DATE OF BIRTH (month, day, and year) Feb. 10. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Varnisher 65

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George H. Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) John H. Hahn 433 N. Robinson St

15 Filed JUL 11 1921 G. H. Crese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1921

17 I HEREBY CERTIFY, That I attended deceased from June 14 1921, to July 9 1921, that I last saw h[illegible] alive on July 9 1921, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebrosis 1 hour

CONTRIBUTORY (Secondary) Carcinoma Rectum (duration) 1 yrs. mos. ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Lear C. M. D.

7/14 1921 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemy	July 13 1921
20 UNDERTAKER	ADDRESS
H Sanders & Son	1710 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55257

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 55257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 S. Patterson Park Ave ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loretta Abel

(a) RESIDENCE. NO. 602 S. Patterson Park Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31, 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Clyde Abel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Clyde Abel
(Address) 602 S. Patterson Park Ave

15 Filed JUL 11 1921 19 G. H. Crese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to July 10, 1921, that I last saw her alive on July 10, 1921, and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dis-colitis

(duration) yrs. mos. 1 day

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Rise, vomiting, diarrhea.

(Signed) Frank Jannopoulos M. D.

, 19 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	July 12 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1700 Eutaw

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55258

CERTIFICATE OF DEATH.

104

D 55258

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2354 Mace St. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Clie F Frazier

(a) RESIDENCE. No. 2354 Mace St., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 29, 94

7 AGE: Years 3 Months 5 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ud

(b) General nature of industry, business, or establishment in which employed (or employer): ud

(c) Name of employer: ud

9 BIRTHPLACE (city or town) (State or country): ud Baltimore Md Maryland

PARENTS

10 NAME OF FATHER: Fannie Fisher (Fannie Fisher)

11 BIRTHPLACE OF FATHER (city or town) (State or country): ud unknown

12 MAIDEN NAME OF MOTHER: Hilda Frazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Maryland

14 Informant, (Address) Hilda F Frazier 2354 Mace St

15 Filed ..... 19 JUL 11 1921 G. H. Crese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7th, 1921, to July 10th, 1921, that I last saw h... alive on July 10th, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteric Intoxication

(duration) x yrs. x mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis Heart (duration) x yrs. x mos. x ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? ud Date of ud

Was there an autopsy? ud

What test confirmed diagnosis? Physical Diagnosis

(Signed) Ed. Gallagher, M. D.

19 (Address) 426 E 23 cor x

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ivy-Avalon Cem — DATE OF BURIAL: July 11 1921

20 UNDERTAKER: Wm R A Elliott — ADDRESS: Ashland Av — 7/21

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Size—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55259

CERTIFICATE OF DEATH.

28 D 55259

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 905 E Preston (St.) 10 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Owen Matthews

(a) RESIDENCE. No. 905 E. Preston St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Owen Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Kinnan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie Donnelly
(Address) 905 E. Preston

15 Filed JUL 11 1921 G. H. Crese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/25 . 1921. to 7/10 . 1921.
that I last saw h alive un 7/9 . 1921.
and that death occurred, on the date stated above, at 8.15 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) oedema of lungs,

(duration) yrs. mos. di.

18 Where was disease contracted if not at place of death? —

Did an uperation precede death? No Date uf

Was there an autopsy? No

What test confirmed diagnosis? Sputum examination

(Signed) A. Bernard Cross, M. D.

July 10, 1921 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral July	12- 1921
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55260

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 55260

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1005 Valley (St.) 10 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Gibson

(a) RESIDENCE No. 1005 Valley St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 10-1903

7 AGE — Years: 17 — Months: 8 — Days: 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John J. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Annie G. Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): John J. Gibson 1005 Valley St.

15 Filed JUL 11 1921 G. H. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June 25 1921 to July 8 1921.

that I last saw h[e] alive on July 8 1921

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Rheumatism

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What lest confirmed diagnosis?

(Signed) W. D. Gibson, M. D.

(Address) 647 Mt. Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral July 13 — 1921

DATE OF BURIAL

20 UNDERTAKER: H. C. Wiedefeld 914 Gramont

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55261

CERTIFICATE OF DEATH.

Grose

104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 923 E. Biddle ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Logue

(a) RESIDENCE. NO. 923 E. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 14, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto-Md.

PARENTS

10 NAME OF FATHER Wm J. Logue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Viola Travelone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs F. Logue

(Address) 923 E. Biddle St

15 Filed JUL 11 1921 G. H. Grose Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1921, to July 9, 1921, that I last saw her alive on July, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chr. Intestinal Indigestion

(duration) yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) Heat prostration & Cardiac Asthenia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) Edward F. Cunningham M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	July 10— 1921

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Greenmt Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 55262

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital St.; 14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Elizabeth Newman

(a) RESIDENCE. No. 1826 Penrose Ave St.. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22" 187[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

069

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George W. Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Annie Ailsworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant George W. Newman (Address) 1826 Penrose Ave.

15 Filed JUL 11 1921 G. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8" 1921

17 I HEREBY CERTIFY, That I attended deceased from July 6 1921, to July 8 1921, that I last saw her alive on July 8th 1921, and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

Osteo sarcoma of left femur

(Duration) yrs. 6. mos. ds.

CONTRIBUTORY (Secondary) Shock. (duration) yrs. mos. 4 hrs. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes. Date of July 8-21

Was there an autopsy? No

What test confirmed diagnosis? Laboratory report.

(Signed) A. C. Conway, M. D.

7/8. 1921 (Address) Franklin Square Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	July 11" 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1955262 HEALTH DEPARTMENT—CITY OF BALTIMORE 1955262

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. ST. WARD)

REGISTERED NO.

(If death occur a hospital or i tion, give its N instead of stree number.)

2-FULL NAME Miss Elizabeth Herrman

(a) RESIDENCE NO. 1876 Penrose Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and S

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
42	11	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. W. Herrman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Ailsworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Geo. W. Herrman
(Address) 1876 Penrose Ave

15 Filed 7/13/21. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1921, to July 8, 19..., that I last saw h... alive on July 8, 19..., and that death occurred, on the date stated above, at 9 30

The CAUSE OF DEATH* was as follows:

Extd Sarcoma of Femur

(duration) yrs. 6 mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of July

Was there an autopsy? No

What test confirmed diagnosis? Lab. repo...

(Signed) Howard M. Bulent

19 (Address) Franklin Square Ho...

*State the Disease Causing Death, or in deaths from Violent... state (1) Means and Nature of Injury, and (2) whether Ac... Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF B... 7-...

20 UNDERTAKER Joseph B. Cook. 1003 W... ADDRES...

6-15-11 M & S Co.—1000 Bks. D 55263

HEALTH DEPARTMENT—CITY OF BALTIMORE D 55263

CERTIFICATE OF DEATH.

15 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1670 W North av. ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah R Lutz

(a) RESIDENCE. No. 1670 W North av. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wht	Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of John Lutz (Dead.)

6 DATE OF BIRTH (month, day, and year) July 6th 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md.

PARENTS

10 NAME OF FATHER Edw. Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co

12 MAIDEN NAME OF MOTHER Rachel Sheridan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co.

14 Informant Fannie Saunders, Overlea, 3821 Roland av.

15 Filed JUL 11 1921 G. H. Cress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 29 1921, to July 9th 1921, that I last saw h[illegible] alive on July 9th 1921, and that death occurred, on the date stated above, at 6-0 P. m.

The CAUSE OF DEATH* was as follows:

Heart Perforation & gradual weakening from Age

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Inability to take nourishment

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) E E Smith, M. D.

7/9. 1921 (Address) 1608 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	July 12 1921
20 UNDERTAKER	ADDRESS 1944
Harry W. Ehlen	W. Mount Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

(Bond) O.K. HK Fosnick Coroner W.D.

D 55264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. + 17 D 55264

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bond.

(a) RESIDENCE. NO. Front Hill. Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Bond. (wife)

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Front Hill, Md.

PARENTS

10 NAME OF FATHER Frank Bond.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eleanor Filghman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) University Hosp. records.

15 Filed JUL 11 1921 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8 1921 to July 9 1921.

That I last saw him alive on July 9 1921.

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
accidental. fell off load of hay
(duration) yrs. mos. 2. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Front Hill Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam. X Ray.

(Signed) H C B Jones, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Hill Md.	7-11 1921
20 UNDERTAKER	ADDRESS
E & B Hasle	115 E Hoff St

Information Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cross

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 55265

55265

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4200 Belview ave ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louisa Holton

(a) RESIDENCE. No. 4200 Belview ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis H. Holton.

6 DATE OF BIRTH (month, day, and year) May 19-1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. Ofd

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Jacob Higgins. Md.

11 BIRTHPLACE OF FATHER (city or town) Bath. (State or country) Maine.

12 MAIDEN NAME OF MOTHER Emily Gorsuch. St. Michaels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Anne E. Holton.

(Address) 4200 Belview ave

15 Filed ..... 19 ..... L. E. Wenn, Registrar

JUL 11 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9- 1921

17 I HEREBY CERTIFY, That I attended deceased from ..... 1903 to July 9- 1921

that I last saw h.. alive on July 9- 1921

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

chronic interstitial nephritis.

arterio-sclerosis. Cardiac dilatation.

(duration) 5 yrs. about. mos. ds.

CONTRIBUTORY (Secondary) chronic authritis & Bronchitis

(duration) 28 yrs. (about) mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical, urinary.

(Signed) Edward Summers, M. D.

, 19 (Address) 2125 Maryland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	July 11, 1921
20 UNDERTAKER	ADDRESS
John O'Mitchell	120 W Fayette st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55266 Gress

63-001 D 55266

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 W Mulberry ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Lee Renner

(a) RESIDENCE: (No. 1116 W Mulberry ST.) WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 5 1914

7 AGE — Years: 7 Months: 4 Days: 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ono

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Ferd. A. Renner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Syfert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Ferd Renner (Address) 1116 W Mulberry st

15 Filed ....., 19 .... Registrar

JUL 11 1921 L. E. Weiss

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-10- 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-9-, 1921, to 7-10-, 1921, that I last saw him alive on 7-10-, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? [redacted]

(Signed) Harry Goldberg M. D.

7/10 1921 (Address) 2210 Gutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catholic Cem

DATE OF BURIAL: 7/11 1921

20 UNDERTAKER: [illegible]

ADDRESS: [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55267 (Case) — 794 D 55267

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 Henry St. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice R. Meyer.

(a) RESIDENCE NO. 1505 Henry St. WARD --------
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 9 mos. 14 ds. How long in U. S., if of foreign birth? ---- yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND OF (or) WIFE of Henry Meyer.

6 DATE OF BIRTH (month, day, and year) Sept. 24th, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	9	14.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER William W. Johnson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary C. Roberts.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Henry Meyer. (husband).
(Address) 1505 Henry Street.

15 (Date received) JUL 11 1921 G. H. Grose Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th, 1921.

17 I HEREBY CERTIFY, That I attended deceased from September 8, 1920. to July 8th, 1921.

that I last saw her alive on July 8th, 1921.

and that death occurred, on the date stated above, at 12.05 p m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage.

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? --------

Did an operation precede death? No. Date of --------

Was there an autopsy? No.

What test confirmed diagnosis? --------

(Signed) Otto M. Reinhardt, M. D.

July 8 1921 (Address) 1017 S. Charles Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Jul 12 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55268

CERTIFICATE OF DEATH.

4 104 D 55268

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 W. Redwood ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Wise

(a) RESIDENCE. No. 618 W. Redwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 22-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER George Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore City

12 MAIDEN NAME OF MOTHER Etta Carey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York State

14 Informant George Wise (Address) 618 Redwood St.

15 JUL 11 1921 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1921.

17 I HEREBY CERTIFY, That I attended deceased from July 8. 1921. to July 9. 1921.

that I last saw him alive on July 9. 1921.

and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH was as follows:

Ileo-Colitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Malnutrition Life

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 618 W. Redwood

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stools + Symptoms

(Signed) W. R. Ingram, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	7/11 1921
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Hpcc.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55269 ✓ D 55269

CERTIFICATE OF DEATH.

2 104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 212 So. Chapel ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Fedrici,

(a) RESIDENCE. NO. 212 So. Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 8/20,

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child, nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.,

PARENTS

10 NAME OF FATHER Francisco Fedrici,

11 BIRTHPLACE OF FATHER (city or town) Itly,
(State or country)

12 MAIDEN NAME OF MOTHER Teresa Stacharowska,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.,

14 Informant Teresa Fedrici,
(Address) 212 So. Chapel Street

15 Filed JUL 11 1921 19 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1921.

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1921, to July 10, 1921, that I last saw h[illegible] alive on July 10, 1921, and that death occurred, on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Chorea Infantum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia and Heart Affection (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?,

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Joseph L. Valentine M. D.

July 11, 1921 (Address) 2 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	July 12 1921
20 UNDERTAKER	ADDRESS
M. J. Sadowski.	709 S. Ann

Spec.—1-10-21 M&T 1500 Bks.

D 55270

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55270

CERTIFICATE OF DEATH.

1-PLACE OF DEATH USPHS Hosp. #56 Baltimore, Md. REGISTERED NO.

CITY OF BALTIMORE: (No. Ft. McHenry, Balto. Md. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Smith

(a) RESIDENCE NO. ~~12~~ USPHS Hosp. #56 Baltimore, ~~Md.~~ WARD 39
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) -----

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	--	--	--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Photostat Operator

(b) General nature of industry, business, or establishment in which employed (or employer): --

(c) Name of employer: --

9 BIRTHPLACE (city or town) (State or country): Washington, D.C.

PARENTS

10 NAME OF FATHER: John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edgar T. Rosenbrock, Registrar

(Address) USPHS Hosp. #56 Ft. McHenry, Md.

15 Filed JUL 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 7, 1921, to July 9, 1921.

that I last saw him alive on July 9, 1921.

and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary Far advance & Active

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) -----

--- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of -

Was there an autopsy? --

What test confirmed diagnosis? Examination Labtry Report

(Signed) Thomas R. Payne M. D.

19 (Address) Senior Surgeon (R)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D. C. DATE OF BURIAL: July 11, 21

20 UNDERTAKER: Hol Linistar ADDRESS 1127 E Balto St

Dental Permit Given

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 55271 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55271

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2546 Madison Ave St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hiss Williams

(a) RESIDENCE. No. 2546 Madison Ave St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 21st 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	76	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Dr J Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Centerville

12 MAIDEN NAME OF MOTHER P. Hiss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Sarah S Lakin

(Address) 2546 Madison Ave

15 JUL 11 1921 ROBERT P. LEA Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 - 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1921, to July 11, 1921, that I last saw her alive on July 11, 1921, and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

Anaemia and Heart Prostation

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? — — —

Did an operation precede death? No Date of — —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas Lo Gaulin, M. D.

, 19 (Address) 2112 Willondale Road Towson Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 13 1921
20 UNDERTAKER	ADDRESS
Henry H Jenkins & Co	Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55272

CERTIFICATE OF DEATH.

+88

D 55272

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Franklin Square Hospital WARD 14)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Buckmon Jr.

(a) RESIDENCE. NO. Owings Mills Md ST., WARD. Owings Mills
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Madge E Buckmon

6 DATE OF BIRTH (month, day, and year) May 13-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent 086

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance National Harrowden Co.

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Owings Mills Md

PARENTS

10 NAME OF FATHER John Buckman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Owings Mills Md

12 MAIDEN NAME OF MOTHER Virginia Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Owings Mills Md

14 Informant (Address) George W. Buckman Lutherville Md

15 Filed JUL 11 1921 ROBERT J. KRAUTER Registrar

Burial transit Clock

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1921, to July 9, 1921.

that I last saw h in alive on July 9, 1921.

and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Toxic Enlargement Thyroid Gland

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-8-21.

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Howard M. Bubert M. D

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Thomas Cemetery	July 13 1921

20 UNDERTAKER J. F. Ehrie ADDRESS Reisterstown

---

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55273 ✓ D 55273

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. ✗108

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Gardner

(a) RESIDENCE. NO. Md Training School for Boys ST., WARD.
(Usual place of abode) East Roxa, Md.

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy MD

(b) General nature of industry, business, or establishment in which employed (or employer) Home for Boys, Md.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salisbury, Md.

PARENTS

10 NAME OF FATHER dead. Not Known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known.

12 MAIDEN NAME OF MOTHER dead Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known.

14 Informant Univ. Hosp. Records.
(Address)

15 Filed JUL 11 1921 ROBERT I. KRAUTER Registrar
Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8. 1921. to July 9. 1921.
that I last saw him alive on July 9. 1921.
and that death occurred, on the date stated above, at 640 P. m.
The CAUSE OF DEATH* was as follows:

Lumbar Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Md. school for Boys East Roxa Md.

Did an operation precede death? yes Date of July 8/1921

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) W. S. Joyce M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	July 11 1921
20 UNDERTAKER	ADDRESS
Lemmon	502 E. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55274

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55274

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital St. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Olin Miller Mall.

(Residence in Baltimore: No. 1707 Smallwood St.; 79 yrs., 2 mos. 4 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH. May 5, 1842 (Month) (Day) (Year)

7-AGE. 79 yrs. 2 mos. 4 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION. (a) Trade, profession, or particular kind of work: Chief Yeoman U.S.N. (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Jacob Mall

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Sarah Beems

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry C. Hall

(Address) 1707 N. Smallwood St.

15-

Filed JUL 11 1921 191... ROBERT J. BRUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 9th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1921, to July 9 1921, that I saw h[illegible] alive on July 9 1921, and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary) Arteriosclerosis & Myocarditis

(Duration) yrs. mos. 3 da.

(Signed) Thomas Dixon M. D.

July 10, 1921 (Address) 1001 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. 4 da. In the State 79 yrs. 2 mos. 4 da.

Where was disease contracted, if not at place of death? 1707 Smallwood St

Former or usual residence Original Residence

19-PLACE OF BURIAL OR REMOVAL. National Cem't. DATE OF BURIAL. July 12, 1921.

20-UNDERTAKER William Cook ADDRESS 3226 Mathews

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stec.—6-9-19—H. P. Co.—1000 Bks.

D 55275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 55275

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levi Johnson

(a) RESIDENCE. NO. 219 S. Caroline St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond, Virginia

PARENTS

10 NAME OF FATHER John W. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital

15 Filed JUL 11 1921 Burial Permit Given Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to July 8, 1921, that I last saw h im alive on July 8, 1921, and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde O'Neill, M. D.

7/9/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn cemetery July 12 21

20 UNDERTAKER — ADDRESS

R C Gross 1405 McElderry

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55276

CERTIFICATE OF DEATH.

D 55276

152

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 620 N. Madison ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Evard.

(a) RESIDENCE. NO. 620 N. Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	W	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2 21

7 AGE Years Months Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robt Evard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Hagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Robt Evard (Address) 620 N Madison

15 Filed JUL 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2 1921 to July 4 1921 that I last saw her alive on July 4 1921 and (that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows: Congenital Malformation of Rectum

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) T T Sutton, M. D.

1921 (Address) 1000 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Arridental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUL 11 1921

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55277

D 55277

CERTIFICATE OF DEATH

51

1-PLACE OF DEATH South Balto. Infant Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1213 Light St. ward) ward)

2-FULL NAME Baby Wagner.

(a) RESIDENCE. No. 2509 Mc Elderry St.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				17 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Jacob Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Ford.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tilman Island Eastern Shore, Md.

14 Informant
(Address)

15 Filed JUL 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7 1921 to July 8 1921, that I last saw him alive on July 8 1921, and that death occurred, on the date stated above, at 2.00 A. m.

The CAUSE OF DEATH* was as follows:

Prematurely born (7½ mos.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Placenta Previa (Caesarean delivery) (duration) yrs. 7 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes (or no) Date of July 7, '21

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Emil Novak M. D.

July 9 1924 (Address) 26 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

JOHNS HOPKINS HOSPITAL JUL 9 1921

20 UNDERTAKER — ADDRESS

ROBERT J. TRAUTEN Commissioner of Health

Vital Statistics Division

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 55278

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N Washington ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Lauer

(a) RESIDENCE. No. 811 N. Washington ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothea

6 DATE OF BIRTH (month, day, and year) Dec 18 1855

7 AGE 65 Years	Months 7	Days 9	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Lauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Kate Shane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Bertha Rosenberger

(Address) 811 N Washington St

15 JUL 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 9 1921, that I last saw h alive on July 9 1921, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation Chronic Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lung

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

(Signed) J H Kirkpatrick M. D.

19 (Address) 800 N Washington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 12 1921
20 UNDERTAKER Wm J. Hartley	ADDRESS 815 N. Wash St

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55279

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55279

CERTIFICATE OF DEATH.

159

1-PLACE OF DEATH
CITY OF BALTIMORE (No. North Point Road near Philadelphia Rd. ST. 76 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hofstetter

(Residence in Baltimore: No. North Point Road St.; 1 yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, April 2, 1857 (Month) (Day) (Year)

7-AGE, 64 yrs. 3 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Joseph Hofstetter

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Hofstetter

(Address) North Point Road

15- JUL 11 1921 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH July 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Shotgun wound Shot gun

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thomas J. Kelly M. D. (Coroner)

July 11 1921 (Address) Room 6 Criminal Court Building

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, 7/12/21

20-UNDERTAKER James Edmonston Miller

ADDRESS 2334 Jefferson Pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Camilla S. Hobbs.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55280

CERTIFICATE OF DEATH.

172 D 55280

REGISTERED NO.....

1-PLACE OF DEATH Franklin Square Hosp. 16

CITY OF BALTIMORE (NO. ..... ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Camilla Sisson Hobbs

(a) RESIDENCE. NO. 1100 N Monroe ST., ... WARD. 16

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Jeremiah Hobbs

6 DATE OF BIRTH (month, day, and year) Nov 13 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Michael Kerby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Camilla Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co

14 Informant (Address) Mrs Elmer Hobbs 1100 N Monroe St.

15 Filed JUL 11 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-1- , 1921 , to 7-9 , 1921 ,

that I last saw h alive on 7-9- , 1921 ,

and that death occurred, on the date stated above, at 11:40 P m.

The CAUSE OF DEATH* was as follows: old age - Fracture (Own) Thigh.

- (duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Fracture Thigh

old age (duration) ..... yrs. ..... mos. 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard M. Bunting, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 12 1921
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 W. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

55281 D 55281

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geraldine Walsh.

(a) RESIDENCE. No. 511 Front Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER John Walsh

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Smith

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed JUL 11 1921 ROBERT J. BRYAN Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1920, to July 11, 1921, that I last saw he alive on July 11, 1921, and that death occurred, on the date stated above, at 1.20 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity
Acute gastro Intestinal indigestion

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) — yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? J. H. H.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) W. Davison, M. D.

7-11-21. 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Hill Cem	July 12 1921
20 UNDERTAKER E Schumacher Son	ADDRESS 1054 Hanover

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55282

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 15 WARD)

REGISTERED NO. 120 D 55282

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thom[redacted] Griffin

(a) RESIDENCE. No. 1648 Ashburton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Addie Griffin

6 DATE OF BIRTH (month, day, and year) July 15, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hatter 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bingham Hopkins Co Balto Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Michael Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary J Halpin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

11 Informant Mrs Addie Griffin
(Address) 1648 Ashburton St City

15 Filed JUL 11 1921 ROBERT I KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 6 1921, to July 9 1921,

that I last saw him alive on July 9 1921,

and that death occurred, on the date stated above, at 10.10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

Unknown (duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) with uraemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) W B Jones, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 21 1921

20 UNDERTAKER W M Rountree

ADDRESS 2238 W North

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55283

CERTIFICATE OF DEATH.

D 55283

79

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3301 O'Donnell ST., 76 WARD)

2-FULL NAME Matthew Riedel

(a) RESIDENCE NO. 3301 O'Donnell ST., 76 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18-1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Riedel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Kremer

(Address) 3201 O'Donnell St

15 Filed JUL 11 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1921, to July 7, 1921, that I last saw him alive on July 7, 1921, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Collenberg, M. D.

July 9, 1921 (Address) 1810 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	July 12 1921
20 UNDERTAKER Lilly & Zuke	ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

14 D 55284

49309
D 55284

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. John Hopkins Hospital ST.: 710 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Vici

(a) RESIDENCE. NO. 3713 E. Pratt St. Baltimore Md. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child. ppb

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Vici

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Dambrosio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUL 11 1921 ROBERT F. KRAUTZ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9- 1921

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1921, to July 9, 1921, that I last saw h Ez alive on July 9, 1921, and that death occurred, on the date stated above, at 10 20 m. P. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) —
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool Cultures Agglutination

(Signed) ....., M. D.

7-10-, 1921 (Address) 1114

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	July 12 1921
20 UNDERTAKER Lilly & Zeile	ADDRESS 403 S. Wolfe St.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55285

29 D 55285

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3511 Roland Ave. ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Tyson.

(a) RESIDENCE NO. 3511 Roland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Jerome B. Tyson.

6 DATE OF BIRTH (month, day, and year) Oct 13 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	8	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew H. Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Bowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs David H Tyler.
(Address) 3511 Roland ave.

15 JUL 11 1921 BOARD OF HEALTH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1921, to July 11, 1921.

that I last saw her alive on July 10, 1921

and that death occurred, on the date stated above, at 3:15 A. m.

The CAUSE OF DEATH* was as follows:

Ch. valv. heart

several
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Heat

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo W Tyler M. D.

7/11 1921 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Cem. Hampden	July 13 1921

20 UNDERTAKER Leavenworth & Son

ADDRESS 3617 Eastern ave.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 55286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 55286

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No Aged Women's Home ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie A. Brown

(a) RESIDENCE. NO. 1400 W Lexington ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	W'H	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1st 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Middlesex Co. Va

PARENTS

10 NAME OF FATHER Vincent Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middlesex Co Va

12 MAIDEN NAME OF MOTHER Julia Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ella F Jones
(Address) Metro

15 JUL 11 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to July 10, 1921, that I last saw h alive on July 7, 1921 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Norwood, M. D.

(Address) 939 W Fayette St

July 11 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	July 12 1921

20 UNDERTAKER Geo J Smith ADDRESS 1000 W Fayette st

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55287 — 120 — D 55287

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 W. Mulberry St. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh J. Byrne

(a) RESIDENCE. No. 1102 Mulberry St. ST., WARD.

(Usual) place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 12th. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman (City) 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Dennis Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Catherine Byrne (Address) 1102 W. Mulberry St. City

15 Filed JUL 11 1921 [redacted] Registrar [redacted] Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th. 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1921, to July 9, 1921, that I last saw him alive on July 9, 1921, and that death occurred, on the date stated above, at 6 3/4 7 m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatis Nephritis

(duration) 4+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Edward V. Cuddahee, M. D.

7/11, 1921 (Address) 24 4 Fallois Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 7-11-1921

20 UNDERTAKER H. C. Brauning Sons — ADDRESS 517 N. Schroeder

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55288

CERTIFICATE OF DEATH.

79 D 55288

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 200 E.Lanvale ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sterrett Gist

(a) RESIDENCE. No. 200 E Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 50 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If married, widowed, or divorced
(or) WIFE of Joseph M. Gist

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Joshua Cockey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nancy Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Mrs Branford Lynch
(Address) 200 E.Lanvale St.

15 Filed JUL 11 1921 19 ROBERT J. TRUITT Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1921, to July 11, 1921, that I last saw h[illegible] alive on July 10, 1921, and that death occurred, on the date stated above, at 9:00A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic congestion of lungs (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) R. C. Melly, M. D.

7/14, 1921 (Address) 1903 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sykesville, Md	7-13-21 19

20 UNDERTAKER H.E.Hughes ADDRESS 424 N. Broadway.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 50 D 55289

D 17
D 55289

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) No. John Hopkins Hospital ST.: 7 WARD)

2-FULL NAME Germain Casanave

(a) RESIDENCE. No. 1213 Eleventh St Altoona Pa WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? Not known mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 23 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Harness Mfg

(b) General nature of industry, business, or establishment in which employed (or employer) 088

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Francis Casanave

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) John Hopkins Hospital Records

15 Filed JUL 12 1921 Registrar G. H. Grese

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 1921 to July 11 1921, that I last saw him alive on July 11 1921, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia - 2 days
Diabetes Mellitus - years ?
Peri Prostatic abscess - Jan 1 - 1921
Myocarditis - (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb. 8 1921

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Williamson M. D.

19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Altoona Pa. DATE OF BURIAL July 12 1921

20 UNDERTAKER Henry Horch Son ADDRESS 1301 E Eager

CAUSE OF DEATH to be plainly written, and no abbreviations used. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55290

CERTIFICATE OF DEATH.

X 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna B. Talley

(a) RESIDENCE. NO. ... Mankton, Md. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph A Talley

6 DATE OF BIRTH (month, day, and year) Jan 26 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Greenhill Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Nanny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nannie B. Talley
(Address) Mankton Md

15 Filed JUL 12 1921 L. E. Webb Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1921, to July 12, 1921, that I last saw her alive on July 12, 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Cystic Bladder

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 11, 21

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) S. W. Kenney M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manktown Md	July 14 19
20 UNDERTAKER	ADDRESS
Wm Cook	Rt 6 Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT NECESSARY TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Cert 44915 D 55291

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

104 D 55291

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Johns Hopkins Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Cowden

(a) RESIDENCE. NO. 86 Duncan St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23-21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph M Cowden

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Marjorie K. Tudor

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUL 12 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1921, to July 10, 1921, that I last saw h. alive on July 10, 1921, and that death occurred, on the date stated above, at 7 5 P m. m.

The CAUSE OF DEATH* was as follows:

acute gastro intestinal indigestion

(duration) yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes Was test confirmed diagnosis? Yes by Dr Cowden

(Signed) W. Davison M. D.

7-11-21 19 (Address) 4th Ed

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL July 12 1921

20 UNDERTAKER Philip Herwig — ADDRESS 2006 Orleans

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 55292

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2206 N Calvert ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adeline Norris

(a) RESIDENCE. NO. 2206 N. Calvert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm B Norris

6 DATE OF BIRTH (month, day, and year) Feb 9, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not Emp. Old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER Chas. Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Sarah A Lowry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Harriett C Norris (Address) 2206 N Calvert St

15 JUL 12 1921 Registrar L. L. Wahl

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1921, to July 10, 1921, that I last saw h or alive on July 9th, 1921, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heat Stroke

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J Watson M. D.

(Address) 212 E St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mound DATE OF BURIAL July 12 1921

20 UNDERTAKER John Whitehill ADDRESS 1201 W. Fayette St.

CAUSE OF DEATH must be properly classified. Use Standard Certificate. Every question must be answered on this certificate, so that it may

D 55293

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 ✓ D 55293

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Druid Apartments ST.: 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert F. Robinson

(Residence in Baltimore: No. Mt Royal & Reservoir St.; 17 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Feby (Month) 17 (Day), 1904 (Year)

7-AGE: 17 yrs. 4 mos. 24 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Balto

PARENTS

10-NAME OF FATHER: Harry S. Robinson

11-BIRTHPLACE OF FATHER (State or country): Harford Co Md

12-MAIDEN NAME OF MOTHER: Carrie D. Fiorman

13-BIRTHPLACE OF MOTHER (State or country): N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry S. Robinson

(Address) Druid Apartments

15 JUL 12 1921 191 J. F. Wood REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 11 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1921 to July 10 1921 that I saw h[illegible] alive on July 10 1921 and that death occurred, on the date stated above, at 6.05 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 5 yrs. mos. ds.

Contributory (SECONDARY) Myocardial insufficiency (Duration) [illegible] yrs. 2 mos. ds.

(Signed) [illegible] M. D.

7/12, 1921. (Address) 1008 Calhedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cem — DATE OF BURIAL: July 12, 1921

20-UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fay[illegible]

N. B.—Every item of the information called for must be given if possible. Any space left blank must be explained. Be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Gross

Spencer—6-9-19—H. P. Co.—1000 Bks.

D 55294

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55294

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 18 E. Bond St ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Klarans

(a) RESIDENCE. No. 18 E Bond St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm Klarans

6 DATE OF BIRTH (month, day, and year) December 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Ades

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1411 E Baltimore St

15 Filed JUL 12 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to July 11, 1921, that I last saw h[illegible] alive on July 11, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis & Ch. Endocarditis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. N. Morrison M. D.

, 19 (Address) 1213 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rehrem Rosedale	July 12 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balto

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C-55295 ~~C-55295~~ 64 D 55295

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2656 Benedict St ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mollie Friedman

(Residence in Baltimore: No. 2656 Benedict St St.; 12 yrs. — mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... Unknown ..... 1 .....
(Month) (Day) (Year)

7-AGE, ... 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Friedman

(Address) 2656 Benedict St

15-

Filed JUL 12 1921 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July ..... 11 ....., 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1921, to July 11 1921, that I saw her alive on July 12 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage .....

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry Glassman M. D.

July 12, 1921. (Address) 2687 West Lexington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 2656 Benedict St

19-PLACE OF BURIAL, OR REMOVAL. Hebrew Rdg Rd. DATE OF BURIAL, July 12, 1921

20-UNDERTAKER M. A. Levinson ADDRESS 1127 E Balto St

Important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55296

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1008 Mc Culloh ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Virginia Ball

(a) RESIDENCE. NO. 1008 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 00 yrs. mos. 02 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1863

7 AGE Years 58 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General home work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jason Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rebecca Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Charles E Bell

(Address) 1326 N. Fremont Ave

15 Filed JUL 12 1921 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1921, to July 9 1921.

that I last saw h.. alive on July 9 1921.

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Garland Schmelz M. D.

July 11 1921 (Address) 1534 E. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL July 12 1921

20 UNDERTAKER David H. Kemsley

ADDRESS 778 W Baltimore

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55297

CERTIFICATE OF DEATH.

28 D 55297

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 William ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Gardner

(a) RESIDENCE. NO. 1513 William ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cyrus Gardner

6 DATE OF BIRTH (month, day, and year) Feb 2, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Jno. Sappington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliz. Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Cyrus Gardner (Address) 1513 William St.

15 Filed JUL 12 1921, 19.... L. E. Wolpe REGISTRAR. C. H. Cresse.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/10 1921

17 I HEREBY CERTIFY, That I attended deceased from 7/8, 1921, to 7/10, 1921, that I last saw h.. alive on 7/10, 1921, and that death occurred, on the date stated above, at 1.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Otilio S. Fowler, M. D.

7/8, 1921 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	July 12, 1921

20 UNDERTAKER ADDRESS

E. J. Fanning & Son 1460 Battery Ave.

CAUSES OF DEATH should be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55298

D 55298

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Wilkens Av ST.; 20 WARD)

2-FULL NAME Catherine Tuttle

(a) RESIDENCE. NO. 2204 Wilkens Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced (or) WIFE of Thomas Tuttle

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Geary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thomas Tuttle

Address 2204 Wilkens Av

15 Filed . 19 Registrar

12,102 JUL 17 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1921

17 I HEREBY CERTIFY, That I attended deceased from July 6 . 1921 , to July 10 . 1921 .

that I last saw her alive on July 10 . 1921 .

and that death occurred, on the date stated above, at 11 40 a.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Apoplexy)

Arteriosclerosis.

(duration) Uncertain

CONTRIBUTORY (Secondary) Endocarditis Pulmonary Oedema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert A Gutsch M. D.

7/11 . 1921 (Address) 215 Wilkens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	July 13 1921
20 UNDERTAKER	ADDRESS
Wilson Father & Sons	[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55299

CERTIFICATE OF DEATH.

119 D 55299

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ~~ST.~~ 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Tubman

(a) RESIDENCE. No. 252 S. Spring St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JUL 12 1921, 19 G. E. Grey Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 6, 19 21 to July 9, 19 21, that I last saw her alive on July 9, 19 21, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute alcoholism

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Clyde McKee, M. D.

7/11/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kent County Md. DATE OF BURIAL July 12 1921

20 UNDERTAKER George F. Rust ADDRESS 1230 Harford Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55300

CERTIFICATE OF DEATH.

8/4 D 55300

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Hollins St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Francis Trinkaus

(a) RESIDENCE. No. 1602 Hollins St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry J. Trinkaus

6 DATE OF BIRTH (month, day, and year) May 11 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Sebastian Dannert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Voigt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry J. Trinkaus (Address) 1602 Hollins St.

JUL 12 1921

G. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/10/21. 19

17

I HEREBY CERTIFY, That I attended deceased from June 6, 19 21, to July, 19 21,

that I last saw her alive on July 10, 19 21,

and that death occurred, on the date stated above, at 10.30 (a) m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis (5 yrs.) +

Senile Dimentia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Edward [illegible] Lukens, M. D.

7/11. 19 21. (Address) 20 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 13 1921
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Baltimore Md.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55301

D 55301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 Park St.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elisabeth Mayer

(a) RESIDENCE. No. 311 Park St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (HUSBAND) (or) WIFE of Conrad Mayer (dec.)

6 DATE OF BIRTH (month, day, and year) May 4th 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (own) Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Gr. Bardrück Germany

PARENTS

10 NAME OF FATHER Gotlard Hügelmeier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John L. Mayer (Address) 311 Park St

15 Filed JUL. 12-1921, 19 L. R. Webb Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10. 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1921, to July 10, 1921, that I last saw h[illegible] alive on July 10th, 1921, and that death occurred, on the date stated above, at 8:50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) E. J. Mayer M. D.

July 11 1921 (Address) 827 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 13 1921
20 UNDERTAKER	(ADDRESS)
Wm Rowkow	230 N. Greene

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

55302 HEALTH DEPARTMENT—CITY OF BALTIMORE 55302

CERTIFICATE OF DEATH. 102

1-PLACE OF DEATH Smtt Baltimore General Hospital REGISTERED No.

CITY OF BALTIMORE: (No. 1213 Light ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kacprzycki

(a) RESIDENCE. NO. 11 Locust Street ST. Curtis Bay WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary C. Kacperzycki

6 DATE OF BIRTH (month, day, and year) March 9, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29 years.	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Riveter.

(b) General nature of industry, business, or establishment in which employed (or employer) 019

(c) Name of employer None at present

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Frank Kacprzycki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Olchenki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Mary Kacprzycki 11 Locust St.

15 Filed JUL 12 1921 19 G. H. Greco Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7. 1921. to July 10 . 1921.

that I last saw h im alive on July 10 . 1921.

and that death occurred, on the date stated above, at 6 05 A m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post gastric Dilatation of Stomach

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes. Date of July 8-1921.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. M. Hayes M. D.

. 19 (Address) 213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	July 13 1921
20 UNDERTAKER	ADDRESS
Margaret S. Flynn	1423 Light St.

TION is very important. See instructions on back of certificates.

Spec. 6-8-19—H. P. Co.—1000 Bks.

55303 C. H. Grace

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

109 REGISTERED NO. 55303

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Abigail Mercy Hospital ST.: WARD)

2-FULL NAME Robinson

3) RESIDENCE. No. Sidney P.O. Anne Arundel Co. Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ — Lottie Robinson

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER David Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Betty ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lottie Robinson
(Address)

15 JUL 12 1921 C. H. Grace. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1921, to July 9, 1921, that I last saw him alive on July 9, 1921, and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
(Incarcerated Hernia)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? yes Date of July 9 1921

Was there an autopsy? yes

What test confirmed diagnosis? Operative findings

(Signed) John J. Brown, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mulley Meeks. A.A. Co.	July 10 1921

20 UNDERTAKER — ADDRESS
Jas. M. Skinner 623 E. Madison St

TION is very important. See instructions on back of certificates.

Grese

55304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

642 55304

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2558 Hollins ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.))

2 FULL NAME John F. Hanlon

(Residence in Baltimore: No. 2558 Hollins St.; yrs. 44 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Married

6-DATE OF BIRTH, Dec (Month) 4 (Day), 1877 (Year)

7-AGE, 44 yrs. 7 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): Hahn Engine Co

9-BIRTHPLACE, (State or Country), Balto City.

PARENTS.

10-NAME OF FATHER, —— Hanlon

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Balto City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophie Hanlon

(Address) 2558 Hollins St

15- JUL 12 1921, 191..., C. H. Grese, M. D., Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

July 12 1921 (Address) 710 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, July 14, 1921

20-UNDERTAKER John Howard & Son — ADDRESS 901 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1804 D 55305

D 55305

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 E. Lafayette Ave — 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Kahn

(a) RESIDENCE. NO. 2013 E. Lafayette Ave ~~ST.~~ WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Kahn

6 DATE OF BIRTH (month, day, and year) Feb. 12, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	72	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saloon keeper. retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer In business for self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Herman Kahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Henrietta Kahn 2013 E. Lafayette Ave

15 Filed JUL 12 1921 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1914, to July 10, 1921, that I last saw h. alive on July 10, 1921, and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema (duration) 12 hours

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. D. Steerken, M. D.

7/11/1921 (Address) 3949 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery Inc. DATE OF BURIAL July 12 1921

20 UNDERTAKER Katz & Johnson ADDRESS 1442 Druid Hill Ave

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55306 — D 55306

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2560 W. Fayette ST., 20 WARD)

2-FULL NAME William Rankle.

(a) RESIDENCE. No. 2560 W. Fayette ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or WIFE) of Mary Nagles.

6 DATE OF BIRTH (month, day, and year) May 8, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired mail Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer U. S. Postal Service Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country) Otho Carroll Co. Md.

PARENTS

10 NAME OF FATHER Otto Kaufer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Rankle (Address) 2560 W. Fayette St.

15 Filed JUL 12 1921, 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 - 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2 - 1921, to July 10 - 1921.

that I last saw h alive on July 10 - 1921.

and that death occurred, on the date stated above, at 10 1/2 - a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 16 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. O. Johnson M. D.

19 (Address) 827 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudan Park Cemetery	July 13 1921
20 UNDERTAKER George J. Rust	ADDRESS 1735 Harford Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55307

CERTIFICATE OF DEATH.

28 D 55307

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1337 Whatcoat ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Hofstains

(a) RESIDENCE. NO. 1337 Whatcoat ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George Hofstains

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Maryland

12 MAIDEN NAME OF MOTHER Emma Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Johnson
(Address) 1337 Whatcoat St

15 Filed JUL 12 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7 . 1921 . to July 10 . 1921 .

that I last saw him alive on July 9 1921 . 19 .

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Clinical

(Signed) Charles E. Clark . M. D.

7-11. 1921 (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Aug. 13. 1921

20 UNDERTAKER James H. Dennis. ADDRESS 1303 Pennsylvania Ave

D 55308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55308

CERTIFICATE OF DEATH.

165

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1343 N. Calhoun St. 7W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Almena Williams

(Residence in Baltimore: No. 416 Eisden St.: yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 8 (Day), 1920 (Year)

7-AGE, 1 yrs. 2 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none (Infant)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Robt. Williams

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Ruth Rogers

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Robt. Williams

(Address) 416 Eisden St.

15- Filed JUL 12 1921 191..... ROBERT P. KRAUTHS Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the date stated above.

The CAUSE OF DEATH* was as follows:

Burns of mouth, throat & asophagus (Swallowed Babbitts Lye)

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. A. D. Hennessy M. D. (Coroner.)

July 10 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, July 13, 1921

20-UNDERTAKER James H. Dennis ADDRESS 1303 Pulaski St.

CAUSE OF DEATH must be plainly written. All questions must be answered if important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55309

CERTIFICATE OF DEATH.

28

D 55309

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp. M. J. H. ST.: 15 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flora Collins

(a) RESIDENCE. NO. 1403 N. Calhoun ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph Collins

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Sam. Wills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records

(Address)

15 Filed JUL 12 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17

I HEREBY CERTIFY, That I attended deceased from July 1st, 1921, to July 11th, 1921, that I last saw h er alive on July 11th, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis and Tuberculous Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 5 mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of the Sputum

(Signed) R. Mendola, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Dakota Cem.	July 14 21
20 UNDERTAKER James. H. Dennis.	ADDRESS 1303 Pratt St

CAUSE OF DEATH to plainly written, so that a copy may be made therefrom. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55310

CERTIFICATE OF DEATH.

D 55310

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 76 WARD)

2-FULL NAME Charles Jones

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Norfolk, Virginia

PARENTS

10 NAME OF FATHER: Jim Swift

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mathis Co., Virginia

12 MAIDEN NAME OF MOTHER: Margaret Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond, Virginia

14 Informant (Address): Hospital Records, New City Hospital.

15 Filed JUL 12 1921 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1921, to July 8, 1921

that I last saw him alive on July 8, 1921

and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Myocardial insufficiency

(duration) — yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde [illegible], M. D.

7/9/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	JUL 1921
20 UNDERTAKER	ADDRESS
ROBT. J. KRAUSE	Commissioner Health.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55311 ✓

D 55311 CERTIFICATE OF DEATH. 115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Haight

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 1858

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broom-maker 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JUL 12 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1921 to July 8, 1921, that I last saw him alive on July 8, 1921, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Purulent Cholecystitis
Acute Peritonitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Operative Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 5-1921

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Clyde A. O'Neill, M. D.

7/9/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JUL 1 1921

Commissioner of Health

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55312

CERTIFICATE OF DEATH.

80 D 55312

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 W. Mulberry ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Carl

(a) RESIDENCE. NO. 1005 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Carl

6 DATE OF BIRTH (month, day, and year) Jan 15 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinetmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Carl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Brauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Carl (Address) 1005 W. Mulberry St.

15 JUL 12 1921 ROBERT F. FRAZIER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from 8.30 a m July 11, 1921, to 10.30 A m July 11, 1921, that I last saw him alive on July 11, 1921, and that death occurred, on the date stated above, at 10.30 A.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris, and Arterio-sclerosis -

(duration) some 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart + acute attack of Colitis (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of n

Was there an autopsy? No

What test confirmed diagnosis? Phys Exam.

(Signed) Robert W. Shipplein, M. D.

July 11 1921 (Address) 710 1016 Mad. Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cemetery	July 14 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55313

CERTIFICATE OF DEATH.

64 D 55313

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1101 N. Mount ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Addison Cover

(Residence in Baltimore: No. 1101 N. Mount St. St.: 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, Feb. 16, 1859 (Month) (Day) (Year)

7-AGE, 62 yrs. 4 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dispatcher (R.R.)
(b) General nature of industry, business, or establishment in which employed (or employer): (Retired) 013

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Cover

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary S. Harris

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. I. L. Cover

(Address) 1101 N. Mount St.

15-JUL 12 1921 ROBERT J. BRAUTER

Filed ....., 191... Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. D. Kenneran M. D. (Coroner.)

July 12, 1921 (Address) 2802 Edgemont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Ridge Cemetery

DATE OF BURIAL, July 13 1921

20-UNDERTAKER, Pelham & Sons

ADDRESS, 1324 Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D 55314

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55314

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Lamon ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H Snowden

(a) RESIDENCE. NO. 1606 Lamon ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of June 14, 1866

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	June		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Snowden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Annie Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard County

14 Informant Della Snowden (Address) 1606 Lamon St.

15 Filed JUL 13 1921 19 C. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from January, 1921, to July 11, 1921, that I last saw him alive on July 11, 1921, and that death occurred, on the date stated above, at 2.25 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Influenza + Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas Jones, M. D.

, 19 (Address) 2802 Rosedale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	July 14 1921
20 UNDERTAKER R. L. Graham	ADDRESS 649 W. Lee St.

TION is very important. See instructions on back of certificates.

D 55315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D 55315

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 521 W.Cross St. ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Pickett.(C)

(Residence in Baltimore: No. 521 W.Cross St. St.: 25 yrs., ------- mos. ------- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored	Married.

6-DATE OF BIRTH. January 1st. 1863., 1 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
58 yrs. 6 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work..... Laborer. Odd
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). North Carolina.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Pickett.(C) wife.

(Address) 521 W.Cross St.

15- Filed JUL 13 1921, 191.... G. H. Gross. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Abotleay.

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

July 12. 1921 (Address) 1017 S.Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt auburn ct

DATE OF BURIAL, July 13. 1921

20-UNDERTAKER J. L. Brant & Son

ADDRESS 1011 N. Monty-

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1040 D 55316

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 505 N. Broadford St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Babin Celesta Jackson

(Residence in Baltimore: No. 505 N. Broadford St.; yrs., 9 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH. Oct. (Month) 30 (Day), 1911 (Year)

7-AGE. ....yrs. 9 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER. Oberlin Jackson

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER. Lillian Kelly

13-BIRTHPLACE OF MOTHER (State or Country). City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Jackson

(Address) 505 N. Broadford

15-

JUL 13 1921 191.... G. H. Grese, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 5th 1921, to July 11 1921, that I saw him alive on July 11 1921, and that death occurred, on the date stated above, at 5.0 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

Broncho Pneumonia

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 1 ds.

(Signed) John Lewis Smith M. D.

July 11, 1921 (Address) 1923 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ashley Cemetery DATE OF BURIAL, July 13 1921

20-UNDERTAKER Milton Davis ADDRESS 3157 W. Eden Pl.

Important. See instructions on back of certificate.

6-9-19—H. P. Co.—1000 Blks.

D 55317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 55317

REGISTERED NO.....

1-PLACE OF DEATH 1748 Lamont ave

CITY OF BALTIMORE: (No 1748 Lamont ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Raymond Nichols

(a) RESIDENCE. No 1748 Lamont ave ST.. 9 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Raymond E Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Va

12 MAIDEN NAME OF MOTHER Edna Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Father R. E. Nichols
(Address) 1748 Lamont Ave

15 Filed JUL 13 1921 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from July 9. 1921 to July 11 1921, that I last saw him alive on July 11 1921, and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro-enteritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted If not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual Clinical tests

(Signed) A. L. Macdonald, M. D.

(Address) 1540 N. Broadway

July 11, 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemt.	July 14 1921

20 UNDERTAKER William Cook ADDRESS 502 E Hoffman.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. F. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55318

CERTIFICATE OF DEATH.

105 D 55318

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Vincents Orphan Asylum ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James McKettrick

(a) RESIDENCE. NO. 1401 Division ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ddd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James F. McKettrick

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown. Jul 3 1921

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant St Vincents Orphan Asy
(Address) 1401 Division St

15 Filed JUL 13 1921 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1921, to July 12, 1921, that I last saw him alive on July 12, 1921, and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Pleo Colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Theo Pleaukes M. D.

(Address) 150 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
~~Carrollton~~ Loudon Park	July 13 1921.
20 UNDERTAKER	ADDRESS
E. N. Offutt, ~~Jr.~~	Baltimore
	228 S. Payson St.

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55319

CERTIFICATE OF DEATH.

64 D 55319

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 N Port ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Zelenka

(a) RESIDENCE. No. 13 N. Port ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Zelenka

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Zelenka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Aron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mary Zelenka
(Address) 13 N Port St

15 Filed JUL 13 1921, 19 ... Registrar G. H. Cress.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1921, to July 11, 1921, that I last saw him alive on July 11, 1921, and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

11

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. Grason M. D.

July 12, 21 (Address) 801 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 14 1921
20 UNDERTAKER	ADDRESS
Frank Brack Son	1906 Eastern Ave

TION is very important. See instructions on back of certificates.

D 55320

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-00 55320

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Joseph Hospital ST.; WARD)
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary B. Kuddeu

(Residence in Baltimore: No. 4003 Roland Ave

St. 71 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug. 6, 1844
(Month) (Day) (Year)

7-AGE, 76 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work H. W. (37)
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, Thos. Slater

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER Heinmeiller

13-BIRTHPLACE OF MOTHER (State or Country), Holland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Chas A. Wolf

(Address) 4003 Roland ave

15-

JUL 13 1921

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Bruises & Lacerations

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Shock.

(Duration) yrs. mos. 1 ds.

(Signed) Geo Edwin Blade M. D.
(Coroner)

July 12 1921 (Address) 143 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem

DATE OF BURIAL, 7/13/21

20-UNDERTAKER J. A. Moran

ADDRESS 300 E Baltimore St.

CAUSE OF DEATH to be plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 55321

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55321

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3004 Arunah Ave 16 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie E Evans

(a) RESIDENCE NO. 3004 Arunah Ave WARD 16
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joshua J Evans

6 DATE OF BIRTH (month, day, and year): May 2 1862

7 AGE — Years: 59 — Months: 2 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm J Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbott Co

12 MAIDEN NAME OF MOTHER: Isabella A Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Talbott Co

14 Informant: Joshua J Evans
(Address): 3004 Arunah Ave

15 Filed ....., 19 ..... Registrar

Dr. Grimpla Scott

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1924

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h... alive on ....., 19.....

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary): Heart Exhaustion

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Anal

(Signed) ..... M. D.

7/13, 1924 (Address) 317 East St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: July 14 1924

20 UNDERTAKER: William Cook — ADDRESS: 582 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information on back of certificate. TION is very important. See instructions on back.

Spec.—1-10-21—M&T—1500 Bks.

D 55322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 55322

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Rutland ave ST., 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John August Naumann

(a) RESIDENCE NO. 821 Rutland ave ST., 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Mrs~~

6 DATE OF BIRTH (month, day, and year): Dec 30 - 1874

7 AGE: ~~Dec 30 1874~~ Years: 46 Months: 6.12 If LESS than 1 day: ~~6~~ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schauffer do

(b) General nature of industry, business, or establishment in which employed (or employer): Freezerong Co

(c) Name of employer: Van Lill Co

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Naumann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma King

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fredrickburg Virginia

14 Informant: Wife (Address): Sadie L Naumann 821 Rutland ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to July 12, 1921, that I last saw him alive on the 12 July 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Heat stroke — I

Chief Cause

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) (Heart) Mitral disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of Death July 12

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas J Timmes, M. D.

19 (Address) 1023 N Wolfe st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: July 15 19 21

20 UNDERTAKER: McGinnis-Carroll — ADDRESS: 4203 Ridgewood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55323

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55323

CERTIFICATE OF DEATH.

115

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3016 Edmondson Ave.n ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Cecelia Mason

(a) RESIDENCE. NO. 3016 Edmondson Ave. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard C. Mason

6 DATE OF BIRTH (month, day, and year) May 8" 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Hiram L. Spicer

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary C. Scharff

13 BIRTHPLACK OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Richard C. Mason (Address) 3016 Edmondson Ave.

15 Filed JUL 13 1921, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12" 1921

17 I HEREBY CERTIFY, That I attended deceased from June 9 . 1921 . to July 12 . 1921 , that I last saw her alive on July 12 . 1921 , and that death occurred, on the date stated above, at 8.15A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cholecystitis

(duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. W. Hill, M. D.

7/13. 1921 (Address) 108 N. Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 15 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Calvert St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Sec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55324

CERTIFICATE OF DEATH.

104

D 55324

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 Hollins St. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Frederick Snoops

(a) RESIDENCE. NO. 1136 Hollins St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4" 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Milton F. Snoops

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Laib

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Milton F. Snoops
(Address) 1136 Hollins St.

15 Filed AUG 13 1921 19 L. E. Wohl Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17

I HEREBY CERTIFY, That I attended deceased from July 4 1921, to July 12 1921, that I last saw him alive on July 12 1921, and that death occurred, on the date stated above, at 6:40 m.

The CAUSE OF DEATH* was as follows:

Convulsions 3 hrs.
(duration) yrs. mos.

CONTRIBUTORY (Secondary) Gastro Enteritis 8
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M. O'Neill, M. D.

7/13. 1921 (Address) 108 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 14 1921
20 UNDERTAKER Joseph L. Cook	ADDRESS 1003 N. Balto St

CAUSE OF DEATH. ATTENTION is very important. See instructions on back of certificates.

D 55325

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp. ST. 12 WARD)

2-FULL NAME Mary Brooks

(Residence in Baltimore: No. 1808 Maryland St.; yrs. 10 mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~M~~ F.

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 26 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... H. work
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE. (State or Country), Harford Co. Md

PARENTS.

10-NAME OF FATHER, Frank Bond

11-BIRTHPLACE OF FATHER (State or Country), Harford Co. Md

12-MAIDEN NAME OF MOTHER Gillman

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas P Brooks

(Address) 1808 Md Ave.

15-

Filed....., 191.....

Registrar. L. E. Wehrly

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10, 1914
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicaemia following criminal abortion

3 mos. about. (Cause unknown)

12 dy (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. T. Kelly M. D.
(Coroner)

July 12, 1914. (Address) 11 E Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	July 13, 1914
20-UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	1725 Ashland Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Diff. Statistics of Occupation important. See instructions on back of certificate.

Gress D 55326 ✓ D 55326

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1114 S Clinton St ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Karbinas

(a) RESIDENCE. NO. 1114 S Clinton St ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Jan 13 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Karbinas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Margaret Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Margaret Karbinas (Address) 1114 S Clinton St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10 1921 to July 12 1921

that I last saw him alive on July 11 1921

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Acute Ulcerative Tonsilitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Infect Anemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) F F Lutzeda M. D.

19 (Address) 500 N Bel Air Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	July 13 1921
20 UNDERTAKER	ADDRESS
Stephen J Fialkowski	

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 55327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 8 Way to Mercy Hospital ST.; 5 WARD)

REGISTERED No. C 183 D 55327

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Downs

(Residence in Baltimore: No. 208 east 2t St. (yrs., 37 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Col'd	Single

6-DATE OF BIRTH, unknown (Month) ....., 1884 (Year)

7-AGE, 37 yrs. — mns. — ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Do

9-BIRTHPLACE. (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Geo Downs

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lena Hollis

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Downs

(Address) 208 east 2t

15- G H Grese

Filed ....., 191... Registrar.

JUL 13 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from stab wound of neck Homicide

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner.)

7-13, 1921 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	7-13-1921
20-UNDERTAKER H. Leon Hall	ADDRESS 1741 Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55328

CERTIFICATE OF DEATH.

41 D 55328

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 212 So. Wolfe ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FRANK ANDREARIK,

(a) RESIDENCE. No. 212 So. Wolfe ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonina Andrearik,

6 DATE OF BIRTH (month, day, and year) January 8-1875.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Life Insurince Agt.,

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Balto. Life Ins., Co.

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Ludwig Andrearik,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Kszawerina Zararaska,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Antonina Andrearik, (wife)

(Address) 212 So. Wolfe Street.

15 Filed JUL 19 1921, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3d, 1921, to July 11, 1921, that I last saw him alive on July 9th, 1921, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Heat Gradual Atrophy and exhaustion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Liver said to be 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Howard L. Silver, M. D.

19 (Address) 3706 Liberty Heights.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.,	July 14th 1921
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55329 ✓ D 55329

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 S Durham ST.; ✓ WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Carter

(a) RESIDENCE. NO. 218 S. Durham St.

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Charles White

(Address): Balto Co

15 Filed . 19 JUL 13 1921 L. E. Wahn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1921, to July 12, 1921, that I last saw h[illegible] alive on July 11, 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Superintendent by Lunacy

(duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Burns, M. D.

. 19 (Address) 124 S. Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	July 14 1921
20 UNDERTAKER	ADDRESS 1502 E Monument
John W Henderson	

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

55330 D 55330

53

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.) 13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Louis N. Gutman

(a) RESIDENCE. No. 2127 Linden Ave (St.) (Ward) Hall I

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dry Goods Retail

(b) General nature of Industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Nathan Gutman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frederick Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mr Gutman

(Address) 2127 Linden Ave

15 Filed ... 19 ... Registrar

JUL 13 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12-1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 . 1921. to July 12 . 1921.

that I last saw him alive on July 11 . 1921.

and that death occurred, on the date stated above, at 5.45 A. m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(duration) Unknown yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 4, 5411

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank C. Marino . M. D.

. 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew

DATE OF BURIAL July 14 1921

20 UNDERTAKER David Goodheim

ADDRESS 1188 W. Baltimore

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55331

CERTIFICATE OF DEATH.

90 D 55331

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N. Belnord Ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Limpert

(a) RESIDENCE. NO. 407 N. Belnord ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Limpert

6 DATE OF BIRTH (month, day, and year) Feb. 12. 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto M.D.

PARENTS

10 NAME OF FATHER George Ruehlich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Oppershaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Snyder
(Address) 402 N. Belnord Ave

15 Filed JUL 13 1921 G K G Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-11-1921

17 I HEREBY CERTIFY, That I attended deceased from July 10th, 1921, to July 12th, 1921, that I last saw h[illegible] alive on July 11th, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Weimer, M. D.

7-12-1921 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	July 14 1921
20 UNDERTAKER H. Sander & Sons	ADDRESS 1710 Lanvale St.

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55332 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55332

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 Chelsea Terrace ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm M. Affayroux

(a) RESIDENCE. No. 2809 Chelsea Terr ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 9 mos. 29 ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary T. Affayroux

6 DATE OF BIRTH (month, day, and year) Sept 13 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Auditor

(b) General nature of industry, business, or establishment in which employed (or employer) B & O. R.R. 13

(c) Name of employer Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Epaulette Affayroux

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary T. Affayroux

(Address) 2809 Chelsea Terrace

15 Filed JUL 13 1921 ROBERT I. KRAUTZ Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1919, to July 13, 1921, that I last saw h... alive on June 13, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Arteriosclerosis (duration) 3 yrs. mos. ds.

Cerebral Thrombosis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2809 Chelsea Ter

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary

(Signed) Hadley S. Beach M. D.

19 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	7/15/21
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	North & Pa

CAUSE OF DEATH should be given in plain terms; indefinite or unknown causes are not sufficient. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55333

CERTIFICATE OF DEATH.

64 D 55333

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4206 Hartford Terrace ST.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Fosdick

(Residence in Baltimore: No. 4206 Hartford Terrace Ste. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Aug. 19, 1867
(Month) (Day) (Year)

7-AGE, 53 yrs. 10 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Peter Frederick

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Katherine Reitz

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna Wehe

(Address) 4206 Hartford Ave.

15- Wife

Filed ..... 191 .....

JUL 13 1921

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 1 hr.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) C. E. Blades M. D.
(Coroner.)

July 13th 1921 (Address) 143 No Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lorraine Cem.	July 14, 1921
20-UNDERTAKER H. Lauderdale	ADDRESS 1710 Park Ave.

CAUSE OF DEATH to be filled in plain terms, so that it may be properly classified. Entire information called for should be given, as it is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55334 | 120 | D 55334

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 S 5th ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Enders Jr.

(a) RESIDENCE NO. 114 S. 5th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Enders.

6 DATE OF BIRTH (month, day, and year) July 16, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 31

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Schulderberg.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER August Enders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Schower

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York City

14 Informant Catherine Enders (Address) 114 S 5th St

15 Filed JUL 13 1921 G. H. G. Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7 1921, to July 12 1921, that I last saw him alive on July 12 1921, and that death occurred, on the date stated above, at 8 40 P. m.

The CAUSE OF DEATH* was as follows:

Uremia Pyelonephritis
Tab Sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Dr. Spencer M. D.

7/17, 1921 (Address) 330 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 15 1921
20 UNDERTAKER	ADDRESS
H. Vanderford Sons	1710 Fleet St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55335

HEALTH DEPARTMENT—CITY OF BALTIMORE

184 D 55335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Russell

(a) RESIDENCE. NO. 2348 Fred'k Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Russell

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
33	"			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Howard Russell

(Address) 2348 Fred'k. Ave

15 Filed JUL 13 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-12, 1921, to 7-12, 1921.

that I last saw h.. w.. alive on 7-12 1921

and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Pelvic peritonitis

(Self-induced): (abortion)

2 weeks.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 4 ds

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 14 1921

20 UNDERTAKER Harry A. Cunnacott 4204 Ridgewood Ave ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55336

CERTIFICATE OF DEATH.

45

D 55336

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Hattie ... Potts

(Residence in Baltimore: No. 2917 W. Lanvale St. St.; yrs., 31 mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F	White	Married

6-DATE OF BIRTH, ... (Month) Unknown (Day) 1890 (Year)

7-AGE,	If LESS than 1 day,
31 yrs. 3 mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),
Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Max Miller

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Potts

(Address) 2917 W. Lanvale

15- Filed JUL 13 1921, 191... ROBERT J. KRAUTER Burial Permit Register

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 24, 1921, to July 13 1921, that I saw h er alive on July 13, 1921, and that death occurred, on the date stated above, at 1.25 A m.

The CAUSE OF DEATH* was as follows:

Hyperemesis Gravida

? (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Operation - Hysterectomy.

(Duration) ....yrs. mos. 16 ds.

(Signed) Frank DeForth Mumston M. D.

July 13, 1921. (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 20 ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 2917 W. Lanvale St.

19-PLACE OF BURIAL OR REMOVAL, Druid Washington Cem. DATE OF BURIAL, July 14 1921

20-UNDERTAKER Jack Myers ADDRESS 1714 E. Lanvale

CAUSE OF DEATH must be plainly stated, so that it may be properly classified. All questions must be answered if possible. Physicians are required to report to the Health Department the existence of any of the diseases mentioned in Section 12 of the Health Ordinance, and the Health Department will furnish blanks for that purpose. Every item is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55337

CERTIFICATE OF DEATH.

64 D 55337

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3514 Fleet St. St., 76 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Yaeger

(a) RESIDENCE NO. 3514 Fleet St., 76 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1- 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	87	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Andrew J Yaeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Yaeger
(Address) 3514 Fleet St.

15 JUL 13 1921 ROBERT J KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from 7/3/21, 19..., to 7/11, 19 21, that I last saw h~~im~~ alive on 7/11/21, 19..., and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Cerebral haemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. McGarrell M. D.

(Address) 633 S. 3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL July 14 1921

20 UNDERTAKER Lilly & Feiler. ADDRESS

BEFORE WRITING ON THIS CERTIFICATE, READ CAREFULLY THE INSTRUCTIONS ON BACK OF CERTIFICATES. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1492 95 55338

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+74 D 55338

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.:) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Downs Staunton Va.

(a) RESIDENCE. No. 323 E Water St., St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown. Unknown.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown. Unknown.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown. Unknown.

14 Informant (Address) Johns Hopkins Hospital Records

15 FILED JUL 13 1921 [redacted] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from July 6. 1921. to July 11. 1921. that I last saw her alive on July 11. 1921. and that death occurred, on the date stated above, at 3.55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebellar Tumor.

/ (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/11/21

Was there an autopsy? Yes

What test confirmed diagnosis? Finding Tumor

(Signed) Wm. R. Reed, M. D.

, 19 (Address) Johns Hopkins Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Covington Va — DATE OF BURIAL: July 13 1921

20 UNDERTAKER: William G Schaeffer — ADDRESS: 816 Belmont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55339

CERTIFICATE OF DEATH.

63

D 55339

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Notre Dame Convent St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Eulogia Zremer

(Residence in Baltimore: No. Dianouth St. & Ashland Ave. St.; 3 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, May (Month) 12 (Day), 1842 (Year)

7-AGE, 79 yrs. 2 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Sch

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Michael Zremer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Kahl

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister M. Dismas

(Address) Notre Dame Dianouth St

15- JUL 13 1921 Burial Permit Clerk

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from at times July 1919, to July 13 1921, that I saw her alive on July 13 1921, and that death occurred, on the date stated above, at 4.40 p.m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

Terminal pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) senile

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. F. Finla M. D.

July 13 1921, (Address) 1100 Eutaw Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Notch Cliff Md	July 15 1921
20-UNDERTAKER	ADDRESS
Frank A. Finla	915 N. Gay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 55340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55340

REGISTERED No. C 25 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 6th. & Highland Ave. St. Brooklyn WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie C. Rice.

(Residence in Baltimore: No. 6th St & Highland Ave Brooklyn. St.: 59 yrs., 6 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Married.

6-DATE OF BIRTH, December 27th 1861., 1 (Month) (Day) (Year)

7-AGE, 59 yrs. 6 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. f37
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William Allen.

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER, Cornelia Walker.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie C. Roberg. (daughter.)

(Address) 6th. St. & Highland Ave.

15- Filed JUL 13 1921 191... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 11th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry. find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Myocardial Insufficiency.
(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(Duration) ...yrs. ...mos. ...ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

July 12. 1921 (Address) 101 E. S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery. DATE OF BURIAL, July 14. 1921.

20-UNDERTAKER E. J. Fanning ADDRESS 1938 E. Lafayette Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Add statement of OCCUPATION, if any, important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

149384 D 55341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-091 D 55341

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital St. 22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Reed

(a) RESIDENCE. No. 599 Mc Henry St St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13-21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John S Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware.

12 MAIDEN NAME OF MOTHER Lillian Miller.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns. Hopkins Hospital Records

15 Filed JUL 13 1921 Robert F. Kelly Registrar Social Service Dept.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from July 9. 1921, to July 11. 1921, that I last saw h[illegible] alive on July 11. 1921, and that death occurred, on the date stated above, at 11½ a. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

7-11-21, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: 7/14 1921

20 UNDERTAKER: Edward Toulson — ADDRESS: 12-17 N Howard St

CAUSE OF DEATH must be plainly written. Use ink. Do not use pencil. Do not make any mark across the face of this certificate. Write on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55342

CERTIFICATE OF DEATH.

D 55342

1-PLACE OF DEATH
CITY OF BALTIMORE, No. Hawkins Point ST.: 25 WARD)
2-FULL NAME Sergt. Freeman
(Residence in Baltimore: No. Hawkins Point St.: yrs., mos. ds.)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

REGISTERED NO. C

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. April 7, 1889
(Month) (Day) (Year)

7-AGE 32 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Day Labour
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country) St Marys Co Md.

PARENTS.

10-NAME OF FATHER. Henry Freeman
11-BIRTHPLACE OF FATHER (State or Country) St Marys Co
12-MAIDEN NAME OF MOTHER Georgana Collison
13-BIRTHPLACE OF MOTHER (State or Country) St Marys Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Freeman
(Address) Hawkins 1425 Argyle Ave

15- Filed JUL 13 1921 ROBERT I KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 11, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1. 1921, to July 8 1921, that I saw h[illegible] alive on July 8 1921, and that death occurred, on the date stated above, at 7 p. m.
The CAUSE OF DEATH* was as follows:

Cancer woma of the Stomach
(Clinical)
(Duration) yrs. 1 3 mos. ds.
CONTRIBUTORY (Secondary) Cancer Lung
(Duration) yrs. 4 mos. ds.
(Signed) Leon S. Hooker M. D.
July 13, 1921 (Address) Curtis Bay Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Quiley Track — DATE OF BURIAL, July 14, 1921

20-UNDERTAKER Jas. M. Skinner — ADDRESS 1655 E. Monument st

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55343

CERTIFICATE OF DEATH.

D 55343

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 413 Markland St. 22nd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretta E Beatty

(a) RESIDENCE NO. 413 Markland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas S. Beatty

6 DATE OF BIRTH (month, day, and year) Oct 29 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER John F. Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Elizabeth Bryden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Thomas S. Beatty (Address) 413 Markland Ave

15 Filed JUL 13 1921 ROBERT I KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17 I HEREBY CERTIFY, That I attended deceased from July-1, 1919, to July-12, 1921, that I last saw h alive on July 12, 1921, and that death occurred, on the date stated above, at 4.30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) General Carcinomata

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 1-21

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) H O Kees M. D.

(Address) 5600 York Rd Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cornelius ville Penn — DATE OF BURIAL July 15 1921

20 UNDERTAKER Wm Cook — ADDRESS 1st & G. Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 55344

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55344

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 869 Harlem Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Henry Pistel

(Residence in Baltimore: No. 869 Harlem Ave St.; 59 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. August 17, 1860 (Month) (Day) (Year)

7-AGE. 60 yrs. 11 mos. 0 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Painter
(b) General nature of industry, business, or establishment in which employed (or employer). Own Employer

9-BIRTHPLACE, (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. Nicholas Pistel

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Barbara Jacobs

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Pistel

(Address) 869 Harlem Ave

15- JUL 13 1921 Filed....., 191... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11 1921, to July 11 1921, that I saw him alive on July 11 1921, and that death occurred, on the date stated above, at 7.30 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. mos. ds.

(Signed) H. M. Stevenson M. D.

7/13, 1921 (Address) 10 W Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. 7/14/21 191...

20-UNDERTAKER. W J Tschan & Sons

ADDRESS Pennsylvania Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

(over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55345

D 55345

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1V V Lanvale St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Clinton

(Residence in Baltimore: No. 1V V Lanvale St.) yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 12th, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), 1V V Lanvale

PARENTS.

10-NAME OF FATHER, Wm Clinton

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Evelin Dyson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evelin Dyson

(Address) 1V V Lanvale St

15-

Filed JUL 14 1921, 191...

C. H. Grese, Registrar.

C. H. Grese

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 12th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12 1921, to July 12 1921, that I saw h alive on July 12 1921, and that death occurred, on the date stated above, at 4 A. M. m.

The CAUSE OF DEATH* was as follows: Premature Birth

7 Months Gestation

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ...yrs. ...mos. ...ds.

(Signed) A. Lee Dey M. D.

7/14 1921 (Address) 72 Monroe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

(over)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55346

CERTIFICATE OF DEATH.

8/V D 55346

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 Harford ave. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Lutz.

(a) RESIDENCE. NO. 1304 Harford ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 60 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Mary Lutz.

6 DATE OF BIRTH (month, day, and year) 1/15/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Baker. 003

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Lutz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) John Lutz 1304 ~~Harford~~ ave.

15 Filed JUL 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April 10th 21 to July 12th 21.

that I last saw h... alive on July 12th 21.

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

1 Vascular Emphysema

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hypertrophy of Heart

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 14 1921

20 UNDERTAKER ADDRESS

George F. Reuter 1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Arteriosclerosis

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55347

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55347

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 4754 Pimlico Road St. 27 WARD)

2-FULL NAME Mary Susan Hull

(a) RESIDENCE. No. 4754 Pimlico Rd. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Near Woodstock Md

PARENTS

10 NAME OF FATHER Samuel Hull

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Sarah Little

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Carroll Co Md

14 Informant [illegible]
(Address) [illegible]

15 Filed JUL 14 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8 1921, to July 13 1921, that I last saw her alive on July 12 1921, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) 1 yrs. mos. ds.

CONTRIBUTORY: Lobar Pneumonia
(Secondary)
(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? 4754 Pimlico Rd

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

19 (Address) 1603 Thoroughfare

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	July 15 1921
20 UNDERTAKER	ADDRESS 1944
Harry W. Eblen	W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55348

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D 55348

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 226 Park Ave ST.: 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Hong Sing

(Residence in Baltimore: No. 226 Park Ave St.: 48 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Yellow

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: ....., 1 ..... (Month) (Day) (Year)

7 AGE: 63 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laundryman
(b) General nature of industry, business, or establishment in which employed (or employer): 41

9 BIRTHPLACE (State or country): China

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (State or country): unknown.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr Fung

(Address) 203 W. Mulberry St.

15 Filed JUL 14 1921 C. H. Crese REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 12th, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Saw him once only, July 12, 1921, to ....., 191..., that I saw him alive on July 12, 1921, and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. D. Lockwood M. D.

July 13, 1921 (Address) 8 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 14th, 1921

20 UNDERTAKER: John O Mitchell — ADDRESS: 1201 N. Fayette, St.

N. B.—Every item of information must be given if possible. Exact statement of OCCUPATION must be made, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 55349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 55349

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 215 Nare St. ST.: 17 WARD)

2-FULL NAME Pattie Smithers

(a) RESIDENCE. NO. 215 Nare ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Smithers

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 137

(b) General nature of industry, business, or establishment in which employed (or employer) Genl house work

(c) Name of employer

9 BIRTHPLACE (city or town) South Boston

(State or country) Virginia

PARENTS

10 NAME OF FATHER Alexander Johnson

11 BIRTHPLACE OF FATHER (city or town) Virginia

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Rosie Chase

(Address) 205 Nare Ave.

15 Filed JUL 14 1921 G. H. Giese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10 1921 to July 12 1921.

that I last saw her alive on July 12 1921.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Garland Schmidt M. D.

July 12 1921 (Address) 1504 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	July 16 1921

20 UNDERTAKER Garland Handley ADDRESS 1128 E Baltimore

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 55350

CERTIFICATE OF DEATH.

D 55350

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2819 Simpson ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Brewington

(Residence in Baltimore: No. 2819 Simpson St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1858 (Year)

7-AGE, 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Clinton N. C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johnson Brewington

(Address) 2819 Simpson St.

15- JUL 14 1921

Filed ..... 191... I. E. Wahl Registrar.

CAUSE OF DEATH to be plainly written. Every question must be answered if important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6 1921, to July 11 1921, that I saw her alive on July 11 1921; and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis & Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) John E. Stewart M. D.

191... (Address) 704 W. Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL, July 14, 1921

20-UNDERTAKER Samuel Hawley ADDRESS 1 Biddle St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55351

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55351

CERTIFICATE OF DEATH.

REGISTERED NO. 574

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 304 N. Caroline ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm G. Arbin

(a) RESIDENCE. NO. 304 N. Caroline ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. 5 ds. How long in U. S., if of foreign birth? 65 yrs. mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~her~~ WIFE of Mary Arbin

6 DATE OF BIRTH (month, day, and year) July 6/56

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry Arbin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Arbin

(Address) 304 N. Caroline

15 Filed JUL 14 1921 E. Wohn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1921

17 I HEREBY CERTIFY, That I attended deceased from ..... 1918 ..... to July 11 1921

that I last saw ~~him~~ alive on July 11 1921

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:-

Valvular Disease of Heart

with Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Excessive Heart.

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination of Urine

(Signed) Benj. O. Hayden M. D.

7/13 1921 (Address) 216 N. Caroline ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	July 14 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be understood by a person not a physician. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55352

CERTIFICATE OF DEATH.

186 D 55352

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. University Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James W. Kriss

(Residence in Baltimore: No. Walnut ave near ash ave Woodlawn St.; yrs., 35 mos. ~~dys.~~)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male.	White	Married

6-DATE OF BIRTH, ... Sept (Month) 28 (Day), 1873 (Year)

7-AGE, 47 yrs. 9 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 015

9-BIRTHPLACE, (State or Country). Austria

PARENTS.

10-NAME OF FATHER. Antonia Kriss

11-BIRTHPLACE OF FATHER (State or Country). Austria

12-MAIDEN NAME OF MOTHER. Don't know

13-BIRTHPLACE OF MOTHER (State or Country). L C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Kriss

(Address) Walnut near Ash ave

15- Filed JUL 14 1921, 19.. I. C. Wilkes Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull; Brain Lacerations
Hemorrhage Shock
Head (Duration) ..... yrs. a few hours.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. a few hours mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

7-12, 1921 (Address) 117 W Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	July 15 1921
20-UNDERTAKER	ADDRESS
Philip Henry	2016 Orleans

N 5547

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of fact important. See instructions on back of certificate.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55353

CERTIFICATE OF DEATH.

D 55353

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2503 Frances ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Wheeler

(a) RESIDENCE. NO. 2503 Frances ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Geo W. Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Mildred Hammett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Geo W. Wheeler
(Address) 2503 Frances

15 Filed JUL 14 1921 L. E. Webb Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 13th 1921 to July 14th 1921, that I last saw her alive on July 14th 1921, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Fall

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) H. H. Hammett, M. D.

, 19 (Address) 1927 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Millstone Woods.	July 15 1921
20 UNDERTAKER J. Tilley & Co	ADDRESS Natl

CAUSE OF DEATH. This information is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall off chair & fracture of
skull & leg.

1905

Spec.—6-9-19—H. P. Co.—1000 Bks.

55354

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 55354

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William H. Kelbaugh

(a) RESIDENCE. NO. Unknown ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Locksmith.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JUL 14 1921 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17 I HEREBY CERTIFY, That I attended deceased from October 16, 1920, to July 12, 1921.

that I last saw h in alive on July 12, 1921.

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) General Lymphadenopathy.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No record at

(Signed) H. A. McKay, M. D.

7/13/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: 7/15 1921

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

D 55355 D 55355

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2216 Rosyln Ave. WARD 15)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Katzenberger

(a) RESIDENCE. No. 2216 Rosyln Ave ST. WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or WIFE of): John H Katzenberger

6 DATE OF BIRTH (month, day, and year): May 12 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Noon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Louis Katzenberger (Address) 2216 Rosyln Ave

15 Filed JUL 14 1921 L. E. Wehr Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 28 1920 to July 14 1921, that I last saw h alive on July 13 1921, and that death occurred, on the date stated above, at 4 AM PM.

The CAUSE OF DEATH was as follows*:

Intestinal Hemorrhage

(duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cirrhosis of Liver

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam

(Signed) [illegible] M. D.

7/14 1921 (Address) 2042 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: July 16 1921

20 UNDERTAKER: Martin Faber & Sons — ADDRESS: 1827 W North Ave

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55356

CERTIFICATE OF DEATH.

120 D 55356

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 W. Lanvale ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Israel Butler

(a) RESIDENCE. No 808 W. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Catherine Butler

6 DATE OF BIRTH (month, day, and year) about 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Expressman

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Lewis Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucretia Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Bessie Butler daughter
(Address) 808 W. Lanvale St.

15 Filed JUL 14 1921 19 C. H. Crese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13- 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-20, 1921, to 7-13-, 1921, that I last saw him alive on 7-11-, 1921, and that death occurred, on the date stated above, at 8,30 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis (duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. D. Cargill, M. D.

7-13-, 1921 (Address) 611 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL July 16 1921

20 UNDERTAKER Jas. M. Johnson — ADDRESS 1224 Eutaw St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55357 — REGISTERED NO. D 55357

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Eastern ave. WARD) 3

2-FULL NAME Mary M. Norberg

(a) RESIDENCE. NO. 1407 Eastern Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Norberg

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Charles Norberg (Address) 1407 Eastern ave

15 Filed JUL 14 1921 C. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1920, to July 12, 1921, that I last saw h[illegible] alive on July 11, 1921, and that death occurred, on the date stated above, at 8:15 P m.

THE CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of some time in Jan. 21.

Was there an autopsy? No

What test confirmed diagnosis? Operation & findings

(Signed) Geo. Heller, M. D.

1/14 1922 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lohwasser	July 14 1921

20 UNDERTAKER Wendell Duffel & Son 37 S Mar

CAUSE OF DEATH in plain terms, so that it may be classified. See back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 55358

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 N Wolfe ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Denison Wiggins

(a) RESIDENCE. NO. 1039 N Wolfe ST.: 7 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 53 years.	dont Know	his exact age		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none odd

(b) General nature of industry, business, or establishment in which employed (or employer) did not work for 2 years

(c) Name of employer dont Know

9 BIRTHPLACE (city or town) (State or country) Gates Co. Virginia

PARENTS

10 NAME OF FATHER James Wiggins

11 BIRTHPLACE OF FATHER (city or town) dont Know (State or country) N Carolina

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) dont Know (State or country) N Carolina State

14 Informant Mrs Martha green (Address) 1039 N Wolfe

15 JUL 14 1921 H. C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from February 20 . 1921 . to July 12th . 1921 . that I last saw him alive on July 12 . 1921 . and that death occurred, on the date stated above, at 3 15 P m.

The CAUSE OF DEATH* was as follows:

Hemorhage of Brain and Paralysis of Left side Had been decreped for several years (duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Cause Heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — — —

Did an operation precede death? No Date of

Was there an autopsy? No — — —

What test confirmed diagnosis? —

(Signed) Thomas J Timms M. D.

. 19 Office (Address) 1028 N Wolfe st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Magnolia Va	July 14th 1921

20 UNDERTAKER Chas G Bailey ADDRESS Hampden Md

CAUSE OF DEATH must be plainly filled in, so that it may be readily understood by those who are not physicians. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55359

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55359

CERTIFICATE OF DEATH.

167

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 Belair Rd ST.: 18 WARD)

2-FULL NAME Samuel D Stanley

(a) RESIDENCE. No. 2115 Belair Rd. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16/1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John D Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret E Baum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John D Stanley

(Address) 2115 Belair Rd

15 Filed JUL 14 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1921

17 I HEREBY CERTIFY, That I attended deceased from July 9. 1921. to July 13. 1921.

that I last saw h[illegible] alive on July 13 1921.

and that death occurred, on the date stated above at 9.50 A. m.

The CAUSE OF DEATH* was as follows:

Accidental
Burned Body by
Hot Fat

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. E. Haarer, M. D.

July 13 1921 (Address) 1301 Hat Pan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 15 1921

20 UNDERTAKER William Cook ADDRESS 526 E North Ave

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55360

CERTIFICATE OF DEATH.

28

D 55360

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 S. Paca ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur J. Norris

(a) RESIDENCE. NO. 535 S. Paca ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 13 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caning chairs

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary's Co. Md

PARENTS

10 NAME OF FATHER George Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Mary Co Md

12 MAIDEN NAME OF MOTHER Florence Furrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Mary Co Md

14 Informant Mr Joseph S. Martin (Address) 535 S Paca st.

15 Filed JUL 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921 to July 13 1921.

That I last saw him alive on June 13 1921 and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Wm F Swinger M.D.

7 14 21 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	July 15 1921

20 UNDERTAKER James Dignan & Son

ADDRESS 1000 S Paca st

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55361

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 D 55361

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 William ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie B. Cusic

(a) RESIDENCE. NO. 902 William ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Cusic

6 DATE OF BIRTH (month, day, and year) Jan 8, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	30	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Gideon Lusby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Flora Oliver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co Md

14 Informant Flora Lusby

(Address) 902 William St

15 Filed JUL 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to July 13, 1921, that I last saw h.. alive on ..., 19..., and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs + Bowels.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Fracture of Hip &c.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Calvert Co. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A Hamm M. D.

, 19 (Address) 1215 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Solomons Island Md Calvert Co	July 16 1921
20 UNDERTAKER	ADDRESS
John F Denny	715 Cathedral

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fracture of hip caused from jumping rope when a child

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55362

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 Callow Ave ST.) (WARD)

2-FULL NAME Minnie Emrich (Emrich)

(a) RESIDENCE. No. 2202 Callow Av ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abram Emrich

6 DATE OF BIRTH (month, day, and year) May 1st 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Mrs Gebhardt) (Address) 2202 Callow Av

15 Filed JUL 14 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11 1921 to July 13 1921 that I last saw h 2 alive on July 13 1921 and that death occurred, on the date stated above, at 11.25 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Mitral insufficiency; Myocardetis

Symptoms (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

July 17, 1921 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	July 15 1921
20 UNDERTAKER	ADDRESS
Wand & Sondheim	118 N Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 55363

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1924 Ramsay St. St. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edwin Heckathorn Sr.

(a) RESIDENCE. No. 1924 Ramsay St. St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Heckathorn

6 DATE OF BIRTH (month, day, and year) Aug. 6th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Retired) Laborer in

(b) General nature of industry, business, or establishment in which employed (or employer) Storage Dept. of

(c) Name of employer B and O R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. Heckathorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ann ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Annie E. Heckathorn
(Address) 1924 Ramsay St.

15 Filed JUL 14 1921 Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7th 1921, to July 13th 1921, that I last saw h alive on July 12th 1921, and that death occurred, on the date stated above, at 12.40 Am

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Paralysis of right Side.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wm. D. Lightner M. D.

(Signed)

7.14. 1921 (Address) 211 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 15 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF MODE OF DYING is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55364

CERTIFICATE OF DEATH

1-64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3021 W. North Ave. ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Marshall Odell

(a) RESIDENCE. No. 3021 W. North Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter G. Odell

6 DATE OF BIRTH (month, day, and year) June 30" 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel Doubleday

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Belt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Samuel Odell
(Address) 1131 N. Fulton Ave.

15 Filed JUL 14 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13" 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1926, to July 13, 1921, that I last saw her alive on July 13, 1921, and that death occurred, on the date stated above, at 10.50P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. L. Dickson, M. D.

, 19 (Address) 3035 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 15 19 21
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 W. Balto St.

CAUSE OF DEATH. [illegible] back of certificates.
TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55365

CERTIFICATE OF DEATH.

108

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 844 Rinehardt ST.: 21 WARD)

2-FULL NAME Mrs. Agnes Wolff.

(a) RESIDENCE. NO. 844 Rinehardt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank Wolff

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Foelle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Mahon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Frank Wolff 844 Rinehardt St

15 Filed JUL 15 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1921, to July 14, 1921, that I last saw her alive on July 14, 1921, and that death occurred, on the date stated above, at 11:15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 11 mos. — ds.

CONTRIBUTORY (Secondary) Pyelitis

(duration) — yrs. 11 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John Erwin M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL July 16 1921

20 UNDERTAKER W. M. Routson

ADDRESS 230 N Green

CAUSE OF DEATH must be plainly written. Avoid use of abbreviations or local terms. Make a separate certificate for each death. Do not use this form for stillbirths. See instructions on back of certificate. INFORMATION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55366 6W D 55366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 422 N. Franklin ST. 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry C. Quigley

(Residence in Baltimore: No. 422 N. Franklin St.: 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	widower

6-DATE OF BIRTH, November, 1858
(Month) (Day) (Year)

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION,
(a) Trade, profession, or particular kind of work: Signpainter
(b) General nature of industry, business, or establishment in which employed (or employer): 050

9-BIRTHPLACE, (State or Country). Ohio

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Police Desk

(Address) Fremont Ave

15- G. H. Grace.

Filed JUL 15 1921 G. H. Grace Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage of
(Duration) 10 minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis
(Duration) yrs. mos. ds.

(Signed) J. A. D. Hennessy M. D.
(Coroner.)

July 13, 1921 (Address) 3802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, July 15 1921

20-UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55367

CERTIFICATE OF DEATH.

122 D 55367

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N. Stricker ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche E. Reynolds

(a) RESIDENCE No. 426 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John C. Reynolds

6 DATE OF BIRTH (month, day, and year) May 24-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	39	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John D. Latchford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Estelle Marlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John E. Reynolds

(Address) 1426 N. Stricker St.

15 Filed JUL 15 1921 19 C. H. C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1921

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to July 13, 1921, that I last saw h[illegible] alive on July 13, 1921, and that death occurred, on the date stated above, at 6,30,P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. mos 30 ds.

CONTRIBUTORY (Secondary) Uterine Hemorrhage

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 18

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) E. M. Thompson, M. D.

19 (Address) 826 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL 7/15 1921

20 UNDERTAKER F. A. Kramer & Son ADDRESS 703 Hanover St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

(Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55368

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55368

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Gilman County School

CITY OF BALTIMORE: (No. Roland Park ST.: 27th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanie Wardlaw Miles

(a) RESIDENCE. NO. Roland ave Roland Park ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND'S~~ (or) WIFE of Francis J. Miles

6 DATE OF BIRTH (month, day, and year) May 9, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. ~~Gentlewoman~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER David Lewis Wardlaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Sarah Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant L. Wardlaw Miles

(Address) Gilman County School Roland Park

15 Filed JUL 15 1921 19 G. H. Cruse Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 29. 1921 to July 13. 1921; that I last saw h.. alive on July 13. 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Coma due to Left Hemiplegia
Prob-ably Cerebral Thrombosis -

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis -

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) M. J. Perlin, M. D.

7/14, 1921 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 15 1921
20 UNDERTAKER Henry W. Jenkins Sons Co	ADDRESS Orchard Mt Calvert

Spec.—6-9-19—H. P. Co.—1000 Bka.

D 55369

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55369

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 Harney ST.: 24 WARD)

2-FULL NAME Mary Estelle Scott

(a) RESIDENCE. NO. 627 Harney ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11/3/17

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	3	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Granger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Scott

(Address) 627 Harney St

15 Filed . 19 Registrar

JUL 15 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17

I HEREBY CERTIFY, That I attended deceased from July 12, 1921, to July 14, 1921, that I last saw her alive on July 14, 1921, and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Stuart, M. D.

(Address) 408 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	7/15/ 19 21
20 UNDERTAKER	ADDRESS
John J Fahey Sons	1318 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. TION is very important. See instructions on back of certificates.

Spec.--8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 55370

CERTIFICATE OF DEATH.

104 D 55370

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2831 O'Donnell ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Howard Davis

(Residence in Baltimore: No. 2831 O'Donnell St.; ..... yrs., 9 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, September 29, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 9 mos. 26 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Benj. F. Davis

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Angie Grove

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Benj. F. Davis .....

(Address) ..... 2831 O'Donnell St. .....

15- JUL 15 1921 G. H. Grese.
Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 15, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14 1921, to July 14 1921, that I saw him alive on July 14 1921, and that death occurred, on the date stated above, at 6.45 a m.

The CAUSE OF DEATH* was as follows:

..... (a) .....
..... Diarrhea & Enteritis .....
.....
..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY ..... (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Geo. J. Ladbelter ..... M. D.

July 15, 1921. (Address) ..... 806 S. Ellwood Ave. .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Edgehill, Charles Town, W. Va. DATE OF BURIAL, July 17, 1921

20-UNDERTAKER Zirkler & Zirkler ADDRESS 1739 E. Eager St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55371

CERTIFICATE OF DEATH.

64 D 55371

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1935 Ramsey St. 70 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August C. Schulz

(a) RESIDENCE. No. 1935 Ramsey St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Mary Schulz

6 DATE OF BIRTH (month, day, and year) Mar. 23 1837

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	84	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired baker

(b) General nature of industry, business, or establishment in which employed (or employer) baker

(c) Name of employer not employed

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Justus Schulz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Ankel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elsie Schulz (Address) 1935 Ramsey St

15 Filed JUL 15 1921 T. E. Wahl Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to July 17, 1921, that I last saw him alive on July 13, 1921, and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) 1 yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) 1 yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death? 1935 Ramsey St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) F. Bentzen, M. D.

7/24, 1921 (Address) 1124 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Park. Gm.	July 16, 21
20 UNDERTAKER C. W. Dill.	ADDRESS 3109 Frederick Ave.

CAUSE OF DEATH in plain terms, so that it may be classified. Indefinite or unsatisfactory terms, such as "Heart Failure," "Exhaustion," "Old Age," "Pneumonia," "Blood Poisoning," "Septicemia," "Tuberculosis," "Cancer," "Abscess," "Paralysis," "Convulsions," "Dropsy," "Uremia," "Meningitis," "Hemorrhage," "Asphyxia," "Debility," "Senility," "Marasmus," "Infection," "Inanition," "Malignant Disease," "Carcinoma," "Sarcoma," "Tumor," "Ulcer," "Gangrene," "Fever," "Influenza," "Grippe," "Diphtheria," "Scarlet Fever," "Measles," "Whooping Cough," "Typhoid Fever," "Typhus Fever," "Malarial Fever," "Erysipelas," "Smallpox," "Rheumatism," "Jaundice," "Childbirth," "Miscarriage," "Abortion," "Stillbirth," "Premature Birth," "Congenital Debility," "Malformation," "Injury," "Accident," "Suicide," "Homicide," "Drowning," "Shock," "Hemorrhage," "Concussion," "Internal Injuries," "Fracture," "Burns," "Scalds," "Wounds," "Drowning," "Poisoning," "Strangulation," "Suffocation," "Hanging," "Gunshot Wound," "Laceration," "Alcoholism," "Drug Habit," should not be used unless supplemented by other information sufficient to indicate the primary cause of death. Deaths from violence must state the means and nature of injury and whether accidental, suicidal or homicidal. Deaths from childbirth must state the duration of pregnancy and whether single or multiple. Deaths from tuberculosis must state the organ affected. Deaths from cancer must state the organ affected. Deaths from ulcer must state the organ affected. Deaths from abscess must state the organ affected. Deaths from paralysis must state the organ affected. Deaths from convulsions must state the organ affected. Deaths from dropsy must state the organ affected. Deaths from uremia must state the organ affected. Deaths from meningitis must state the organ affected. Deaths from hemorrhage must state the organ affected. Deaths from asphyxia must state the organ affected. Deaths from debility must state the organ affected. Deaths from senility must state the organ affected. Deaths from marasmus must state the organ affected. Deaths from infection must state the organ affected. Deaths from inanition must state the organ affected. Deaths from malignant disease must state the organ affected. Deaths from carcinoma must state the organ affected. Deaths from sarcoma must state the organ affected. Deaths from tumor must state the organ affected. Deaths from ulcer must state the organ affected. Deaths from gangrene must state the organ affected. Deaths from fever must state the organ affected. Deaths from influenza must state the organ affected. Deaths from grippe must state the organ affected. Deaths from diphtheria must state the organ affected. Deaths from scarlet fever must state the organ affected. Deaths from measles must state the organ affected. Deaths from whooping cough must state the organ affected. Deaths from typhoid fever must state the organ affected. Deaths from typhus fever must state the organ affected. Deaths from malarial fever must state the organ affected. Deaths from erysipelas must state the organ affected. Deaths from smallpox must state the organ affected. Deaths from rheumatism must state the organ affected. Deaths from jaundice must state the organ affected. Deaths from childbirth must state the organ affected. Deaths from miscarriage must state the organ affected. Deaths from abortion must state the organ affected. Deaths from stillbirth must state the organ affected. Deaths from premature birth must state the organ affected. Deaths from congenital debility must state the organ affected. Deaths from malformation must state the organ affected. Deaths from injury must state the organ affected. Deaths from accident must state the organ affected. Deaths from suicide must state the organ affected. Deaths from homicide must state the organ affected. Deaths from drowning must state the organ affected. Deaths from shock must state the organ affected. Deaths from hemorrhage must state the organ affected. Deaths from concussion must state the organ affected. Deaths from internal injuries must state the organ affected. Deaths from fracture must state the organ affected. Deaths from burns must state the organ affected. Deaths from scalds must state the organ affected. Deaths from wounds must state the organ affected. Deaths from drowning must state the organ affected. Deaths from poisoning must state the organ affected. Deaths from strangulation must state the organ affected. Deaths from suffocation must state the organ affected. Deaths from hanging must state the organ affected. Deaths from gunshot wound must state the organ affected. Deaths from laceration must state the organ affected. Deaths from alcoholism must state the organ affected. Deaths from drug habit must state the organ affected.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55372

CERTIFICATE OF DEATH.

104 D 55372

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 418 S Regester ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus M Rydzewski

(a) RESIDENCE. No. 418 S Regester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wladyslaus Rydzewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ludwika Barnlaz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wladyslaus Rydzewski
(Address)

15 Filed JUL 15 1921 G. H. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1921, to July 14, 1921, that I last saw h[illegible] alive on July 14, 1921, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cholera Infantum

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Heart affection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Joseph L. Valentine M. D.

July 15, 1921 (Address) 2 11 Bd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 16 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Dr. Bressler

Spec.—1-10-21—M&T—1500 Bks.

55373

HEALTH DEPARTMENT—CITY OF BALTIMORE

41 D 55373

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4603 Eastern Ave. ST., 76 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Klimm

(a) RESIDENCE NO. 4603 Eastern Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Klimm

6 DATE OF BIRTH (month, day, and year) July 15-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Seifert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Klimm (Address) 4603 Eastern Ave

15 Filed JUL 25 1921 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1921

17 I HEREBY CERTIFY, That I attended deceased from October, 1920, to July - 13, 1920,

that I last saw her alive on July 13, 1920,

and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Interi st Rectum

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) General Exhaustion

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? None Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) Thos O'Bryan M. D.

15/7/19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Mt. Carmel Cemetery	July 15 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	170 Hoel St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55374 — 104 D 55374

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2419 Oak St. (St.) 12 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Johnson

(a) RESIDENCE: No. 2419 Oak St., St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 1 min.
		5	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baby
(b) General nature of Industry, business, or establishment in which employed (or employer) Baby
(c) Name of employer x

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) Md (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Pigliford

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country) Md

14 Informant Julia Johnson (Address) 2419 Oak St- Balt-

15 Filed ..., 19... G. L. Gross Registrar

JUL 15 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1921, to July 14, 1921, that I last saw h... alive on July 14, 1921, and that death occurred, on the date stated above, at 5:10 a.m.

The CAUSE OF DEATH* was as follows:
Acute Gastro Enteritis
Acidosis

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Error in Diet
Artificial Feeding (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) D. Jakell M. D.

, 19 (Address) x2662 Dol

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 16 1921
20 UNDERTAKER	ADDRESS
Chas R A Clarke	1725 Ashland Ave

D 55375

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 7 2

25

D 55375

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Union Shipyard, Fairfield ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry A. Greenstreet.

(Residence in Baltimore: No. 1513 Curtis Ave. Curtis Bay. St.: 8 yrs., ------- mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, April 5th. 1877., 1 ..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
44 yrs. 3 mos. 8 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Virginia.

PARENTS.

10-NAME OF FATHER, Philip Greenstreet

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Martha Jordan.

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna M. Greenstreet. (wife).

(Address) 1513 Curtis Ave. Curtis Bay.

15-

Filed ....., 191.....

Registrar.

JUL 15 19..

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.
Crushed about the body by accidental falling of lumber.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.

(Address) July 14 1921 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Essex County Va

DATE OF BURIAL, July 16, 1921

20-UNDERTAKER George L. Schwab & Bro.

ADDRESS 2201 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55376

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Frederick Road and College Ave. 545 ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Andrew Linhard

(a) RESIDENCE. No. Frederick Rd. & College Ave ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 11 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White ~~Female~~	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Slater

6 DATE OF BIRTH (month, day, and year) July 18, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Andrew Linhard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helena Feldhaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Helen Linhard

(Address 929 N. Calvert St.

15 Filed . 19 JUL 15 1921 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15 . 1921 . to July 14 . 1921 .

that I last saw h[illegible] alive on July 13 1921 .

and that death occurred, on the date stated above, at 12 40 A m.

The CAUSE OF DEATH* was as follows:

General Carcinoma of abdomen. about

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Metastasis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? Yes Date of May 30-21

Was there an autopsy?

What test confirmed diagnosis? Physical & Surgical

(Signed) W. A Tull . M. D.

7/14. 1921 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/16/21 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calver

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Pylorus.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55377

CERTIFICATE OF DEATH.

64 D 55377

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1746 Clarkson ST.: 23 WARD)

2-FULL NAME Catherine F. Miller

(a) RESIDENCE. No. 1746 Clarkson ST.. 23 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel C. Miller

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
68	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bal'o Md

PARENTS

10 NAME OF FATHER: John Kuber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Fredericka Bontrop

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Samuel C. Miller 1746 Clarkson St.

15 Filed JUL 15 1921. G. H. Grimes Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1. 1921. to July 14. 1921. that I last saw h[illegible] alive on July 14. 1921. and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Dunn M. D.

19 (Address) 1527 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	July 16 1921
20 UNDERTAKER	ADDRESS
Mrs E E Evans & Son	1428 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. Blanks will not be accepted. Ditto marks are not permitted. Carefully read the instructions on back of certificates. ATTENTION is very important. See instructions on back of

D 55378

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55378

CERTIFICATE OF DEATH.

X 181

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. B & O R R Tunnel St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jamy Broquet.

(Residence in Baltimore: No. Ash Cake Va. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Dont Know

6-DATE OF BIRTH, Dont Know, 1 (Month) (Day) (Year)

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt Brooks

(Address) 17 S. Calhoun St

15- FILED JUL 15 1921 191.... [illegible] Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 14, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocuted by accidentally coming in contact with 3rd Rail in R.R. Tunnel (Duration) ..... yrs. a few min.

CONTRIBUTORY (Secondary) Accident (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W.K. Gorsuch M. D. (Coroner)

7-15, 1921 (Address) 113 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. ASHCAKE VA

DATE OF BURIAL. July 15, 1921

20-UNDERTAKER Robert Brookes

ADDRESS 17 S Calhoun St

Spmt. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55379 CERTIFICATE OF DEATH. 28 D 55379

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tbc Hosp ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Smith

(a) RESIDENCE. NO. 1123 Bolton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Divorced

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant (Address)

15 Filed JUL 15 1921 . 19 ROBERT B. [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1921

17 I HEREBY CERTIFY, that I attended deceased from July 6th 1921 to July 12th 1921.

that I last saw h[illegible] alive on July 12th 1921.

and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Tubercle bacilli in sputum

(Signed) Ryder McNeill, M. D

. 19 (Address) Municipal Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 55380 Body at Mercy Hospital Morgue.

HEALTH DEPARTMENT—CITY OF BALTIMORE

To be buried by city

CERTIFICATE OF DEATH.

1921 D 55380

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Guy Taylor

(Residence in Baltimore: No. 610 Cider alley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Sgle

6-DATE OF BIRTH, ... Dont Know, 1 ..... (Month) (Day) (Year)

7-AGE, about 28 years Dont Know yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, " "

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JUL 15 1921 Filed....., 191.... ROBERT J KRUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July ..... 10 ..., 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquiry~~) thereon and from the evidence obtained by said ..... (Inquest, autopsy ~~or inquiry~~) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in Left Breast

a few minutes (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shot Chas. Ford

a few minutes (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Gorsuch M. D. (Coroner.)

7-13..., 1921 (Address) 117 W. Saratoga....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY. DATE OF BURIAL, ..., 19....

20-UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-1-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 55381

D 55381

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal T. Hosp. ST.: 27 WARD)

2-FULL NAME Mary Franklin

(a) RESIDENCE. NO. Melvale School ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rena Franklin
(Address) 131 N. Fremont St.

15 Filed JUL 15 1921 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 14 1921 to July 14 1921.

that I last saw h[illegible] alive on July 14 1921.

and that death occurred, on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? T.B. in sputum

(Signed) Clyde McNeill M. D.

7/14, 1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt. Auburn July 16 1921

20 UNDERTAKER — ADDRESS

John H. Trader 192 N. Fremont St.

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55382

CERTIFICATE OF DEATH.

D 55382

REGISTERED NO. C 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 335 N Bruce ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Ray

(Residence in Baltimore: No. 335 N Bruce St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Unknown, 1 (Month) (Day) (Year)

7-AGE, 75 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gardener
(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

9-BIRTHPLACE, (State or Country). Calvert Co

PARENTS.

10-NAME OF FATHER, William Gay

11-BIRTHPLACE OF FATHER (State or Country). Calvert Gay

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Calvert Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Wickes

(Address) 335 Bruce St.

15-JUL 15 1921 ROBERT J KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 13 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 12 1921, to July 13 1921, that I saw him alive on July 13 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion

(Duration) 75 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. F. Smith M. D.

July 14, 1921 (Address) 11 E N Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Queens Station Calvert Co

DATE OF BURIAL, July 16, 1921

20-UNDERTAKER Edward Pinegold

ADDRESS 1463 Carey St

CAUSE OF DEATH. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55383

CERTIFICATE OF DEATH.

99

D 55383

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin P. Tubbs

(a) RESIDENCE. NO. 1213 John St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Alice Lee Tubbs wife

6 DATE OF BIRTH (month, day, and year) Nov 13 1867

7 AGE	Years	Months	Days	If LESS than 1 day..... hrs. or min.
	53	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Editor

(b) General nature of industry, business, or establishment in which employed (or employer) Star Editor

(c) Name of employer Balto Newspaper

9 BIRTHPLACE (city or town) Wilmington

(State or country) Delaware [illegible] Co. and.

PARENTS

10 NAME OF FATHER Daniel Tubbs

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Delaware [illegible] Co.

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Delaware [illegible] Co.

14 Informant (Address) University Hosp. Records

15 Filed JUL 15 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14. 1921. to July 14 1921.

That I last saw him alive on July 14. 1921.

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Acute diffuse nephritis following Flexner for pyaemia abscedens.

(duration) yrs. mos. 2. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1213 John St. Balto

Did an operation precede death? yes Date of July 13. 1921

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory Findings Autopsy Findings

(Signed) W B Jones, M. D.

7/14 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Denton Caroline Co Md.	July 16 1921

20 UNDERTAKER ADDRESS

Chas. G. Black 747 W. Fayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Physicians are requested to report all deaths promptly. Delay in reporting deaths is a violation of law. Penalty for violation of certificates.

TION is very important. See instructions on back of certificate.

Spec.—8-2414—M. & T.—2000 Blks.

D 55384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D 55384

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1414 Penna Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Savage Jordon

(Residence in Baltimore: No. 1414 Penna. Ave St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Colored	Married

3-DATE OF BIRTH, ... (Month) ..... (Day) 1898 (Year)

7-AGE, 23 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

6-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Daily Taylor Savage

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Nora Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nora Savage

(Address) 1414 Penna Ave

15- JUL 15 1921 ROBERT J. KRAUTER

Filed ....., 191... Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1921, to July 14 1921, that I saw her alive on July 14 1921, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) T. E. Daughtery M. D.

July 14, 1921 (Address) 602 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Penn	July, 191...
20-UNDERTAKER Daniel Easton	ADDRESS 916 Penna Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55385

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Emily Horner

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28 WARD. Hanover Pa.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May - 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
23	23	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hanover Pa

PARENTS

10 NAME OF FATHER John Horner

11 BIRTHPLACE OF FATHER (city or town) — (?)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Ernuder

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) Switzerland -

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Retreat Md.

Filed JUL 15 1921 [illegible] Registrar

Burial permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1921

17

I HEREBY CERTIFY, That I attended deceased from June 12 1921 to June 15th 1921.

that I last saw her alive on June 14 1921.

and that death occurred, on the date stated above, at 7.15 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart.

Sudden -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Depression Psychosis (melancholia) (duration) abt yrs. — mos. 2 1 ds.

18 Where was disease contracted if not at place of death? Hanover Pa

Did an operation precede death? No Date of

Was there an autopsy? No -

What lest confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

July 15 1921 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Hanover	July 17 1921

20 UNDERTAKER Daniel Easton

ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55386

D 55386

CERTIFICATE OF DEATH.

REGISTERED NO. 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Georgiana Taylor

(a) RESIDENCE. No. 3201 N. North Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Mr. Taylor

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

11 Informant Mrs. Imogine Edgerton

(Address) 3201 W. North Ave.

15 Filed JUL 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1921, to July 17, 1921, that I last saw h[illegible] alive on July 17, 1921, and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia

(duration) 7 hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary) Auto-intoxication (duration) 30 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of July 17, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or An deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	July 14 1921

20 UNDERTAKER Wm. E. Blacke ADDRESS 927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not write on back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55387

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 N. Appleton ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Russell Hanna

(a) RESIDENCE. No. 1805 N. Appleton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Grocery store
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry W Hanna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Md

12 MAIDEN NAME OF MOTHER Annie Mediary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs. H. Hanna 1805 N. Appleton St.

15 JUL 15 1921 [illegible] Registrar

Burial Permit Oliver

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1921

17 I HEREBY CERTIFY, That I attended deceased from 7/9 1921 to 7/14 1921.

that I last saw him alive on 7/14 1921.

and that death occurred, on the date stated above, at 1 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation Sclerosis?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mt Washington

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry Russell M.D.

1921 (Address) 1962 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Churchville Harford Co	July 17 1921
20 UNDERTAKER	ADDRESS
Harry W. Ehlen & Son	1945 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations may be used. DURATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55388

CERTIFICATE OF DEATH.

74 D 55388

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 E. 38th ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles M. Stanwright

(a) RESIDENCE. NO. 1005 E. 38th. ST., 13 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs — mos — ds. How long in U. S., if of foreign birth? yrs mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael A. Stanwright

6 DATE OF BIRTH (month, day, and year) Nov. 18-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md.

PARENTS

10 NAME OF FATHER: James B. Stanwright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER: Amelia Chilcoat

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md.

14 Informant (Address): Mrs. Rachael A. Stanwright 1005 E. 38th. St.

15 JUL 15 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from June 24 1921, to July 14, 1921, that I last saw h[illegible] alive on July 11, 1921, and that death occurred, on the date stated above, at 905 A.m.

The CAUSE OF DEATH* was as follows:

(See Numbers)

1 Chronic disease of Heart Dilatation

Auricular Fibrillation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senescence

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? N Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms & Physician

(Signed) Robt B Norwood M. D.

7.15.1921 (Address) 2347 Eastland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bosley's M. E. Cemetery (Balto. Co.)	July 16 1921

UNDERTAKER: Horace H. Burgee ADDRESS: 3631 Falls Rd.

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Physicians are requested to fill out all items of this certificate. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55389 D 55389

CERTIFICATE OF DEATH.

92-010

REGISTERED NO. C 5

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 51 Sommerset ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Drake

(Residence in Baltimore: No. 51 Sommerset St. 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH Oct 1 (Month) (Day), 1897 (Year)

7-AGE. 24 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Do

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Alfred Hunter

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Maggie Lane

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Hunter

(Address) 51 Sommerset St

15-

Filed JUL 16 1921, 191.... G. B. Grove Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2 1921, to July 13 1921, that I saw h[illegible] alive on July 12 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. 7 ds.

(Signed) Richard Gaskins M. D.

July 13, 1921 (Address) 1514 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cemetery DATE OF BURIAL. July 16 1921

20-UNDERTAKER Chas. H. Johnson ADDRESS 1167 N. Gilmor

important. See instructions on back of certificate.

55390

Spec.—6-9-19—H. P. Co.—1000 Bks.

55390

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Sarah Ann ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Fisher

(a) RESIDENCE. NO. 1120 Sarah Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
24	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Davis Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Julia Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Julia Feathers
(Address) 1120 Sarah Ann St

15 [illegible] JUL 16 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1921

17

I HEREBY CERTIFY, That I attended deceased from June 10. 1921. to July 13. 1921.

that I last saw her alive on July 13. 1921.

and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Hawk E. Wagner M. D.

7/16, 1921 (Address) 2056 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 16 1921

20 UNDERTAKER Daniel Easton ADDRESS 916 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. FAILURE TO FILL IN ALL ITEMS OF THIS CERTIFICATE IS VERY IMPORTANT. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55391

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55391

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 272 Huntingdon Ave ST.) 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Elizabeth McDonald

(Residence in Baltimore: No. 272 Huntingdon Ave St.; 50 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
~~Female~~	White	Widow

6-DATE OF BIRTH, May (Month) 22 (Day), 1843 (Year)

7-AGE 78 yrs. 1 mos. 23 da. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Invalid
(b) General nature of industry, business, or establishment in which employed (or employer): Old

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER Solomon Smock

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Asked not Known

13-BIRTHPLACE OF MOTHER (State or Country) Asked Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sadie Parker

(Address) 272 Huntingdon Ave

15- Filed JUL 16 1921 191.... G. H. C[illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 15th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1st 1920, to July 15th 1921, that I saw her alive on July 14th 1921, and that death occurred, on the date stated above, at 7-10 ~~A~~ P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) about 3 yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....

(Duration) 1 yrs. ..... mos. ..... da.

(Signed) W. S. Gallagher M. D.

July 16th 1921. (Address) 17 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191..
Mount A	July 18
20-UNDERTAKER	ADDRESS
D S Marshall 3539	Eut Rd

CAUSE OF DEATH to be filled in plain terms, so that it may be properly important. See instructions on back of certificate.

D 55392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced Dead at Franklin Square Hospital 19 WARD)

REGISTERED NO. C [illegible] D 55392

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No.

2-FULL NAME Charles E Jones

(Residence in Baltimore: No. Colkeysville md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 37 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) marble works

9-BIRTHPLACE, (State or Country) Tennessee

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geare Davis Mastic Co

(Address) Cockeysville Md

15-

Filed JUL 16 1921, 191 C. H. Cross Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July ..... 14 ....., 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Investigation .....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture Skull Internal Injuries Struck by Steering Gear Auto truck while at work Duration Instant yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Benton M. D.
(Coroner.)

July 16 1921 (Address) 700 E Chase St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Jessup Church Yard | DATE OF BURIAL, July 17, 1921

20-UNDERTAKER W C Brooke | ADDRESS Parkton Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55393

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55393

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH Bon Secours ~~Baltimore~~ Hospital

CITY OF BALTIMORE: (No. Fayette & Paulding St. St.; 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Julia Finnegan.

(Residence in Baltimore: No. 822 Somerset St. St.; 70 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Not Known, 1 (Month) (Day) (Year)

7-AGE, 70 yrs. mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Michael Dolfpenny.

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John Finnegan

(Address) 822 Somerset St

15-

Filed....., 191. L. E. Wahl
Registrar.

JUL 18 1921

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11 1921, to July 13 1921; that I saw h[illegible] alive on July 13 1921, and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Cerebral ~~Accident~~ Hemorrhage, Cerebellum (?)

Chronic Nephritis (Hemiplegia)

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) (Over)

(Duration) yrs. mos. ds.

(Signed) D. L. Johnson M. D.

7-15, 1921 (Address) Bon Secours Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State 20 yrs. mos. ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence 822 Somerset St

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery	July 18., 1921.
20-UNDERTAKER	ADDRESS
Henry Storck Son	1301 E Eager St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55394

CERTIFICATE OF DEATH.

1172

D 55394

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adolf Anderson

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Md.

6-DATE OF BIRTH. ....., 1 .....
(Month) (Day) (Year)

7-AGE, 39 about yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Dent. Exam
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country), Sweden (Finn)

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. W. F. Kelly

(Address) 1639 Broadway. N.

15-

Filed JUL 16 1921 191.... G. H. Cruse, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy or inquiry~~) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable fracture Skull & ~~Patient not~~ Caused by a fall from a tower.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

July 15, 1921 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Claremont N.Y.	July 16, 1921

20-UNDERTAKER	ADDRESS
Strouse Jenkins Undr Co	McGuloh & Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 55395

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55395

175-001

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital (STREET AND WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Haley Mafus

(Residence in Baltimore: No. 1719 Orleans st. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Col	Single

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE. 11 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Harry E Waters

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary E Deshield

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Waters

(Address) 1719 Orleans st.

15-

Filed JUL 16 1921 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Hit by Auto (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) M. D.

7-15, 1921 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Corner of Broadway & Orleans St

Former or usual residence 1719 Orleans

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, July 16 1921

20-UNDERTAKER Harry A. Vodery

ADDRESS 1725 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 D 55396

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Leadenhall ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Royal

(a) RESIDENCE. No. 919 Leadenhall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not known

6 DATE OF BIRTH (month, day, and year) Not Known deft

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 58	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitress

(b) General nature of industry, business, or establishment in which employed (or employer) Public school

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Trappe, Md.

PARENTS

10 NAME OF FATHER Wm Henry Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Trappe, Md.

12 MAIDEN NAME OF MOTHER Louisa Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Trappe, Md.

14 Informant Alex Scott

(Address) 663 Pine st

15 Filed JUL 18 1921 I. E. Wohn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3rd, 1921, to July 14th, 1921, that I last saw her alive on July 14th, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Bacillary Dysentery

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. T. Hance, M. D.

7/15, 1921 (Address) 140 W. Hull st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn Ct. July 17 1921

20 UNDERTAKER — ADDRESS

C. W. Brown & Son 108 N. Monty

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55397

D 55397

CERTIFICATE OF DEATH.

168

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1627 Mulberry ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Mack

(Residence in Baltimore: No. 1627 Mulberry St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, May (Month) 8 (Day), 1921 (Year).

7-AGE, ...yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John Mack

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Florence Smith

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Mack

(Address) 1627 Mulberry St

15- Filed JUL 16 1921 191.... G. H. Greer. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 15 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidently Burned
Scalds
while in bed with
Parents
(Duration) ....yrs. ....mos. one day ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) James J. McFeeley M. D. (Coroner.)

July 16, 1921. (Address) 700 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	July 16 1921
20-UNDERTAKER	ADDRESS
Brown & Leland	1404 Pennsylvania Ave

N. B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 55398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 175-001

D 55398

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Biedlers And Sellman Hospt WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E Dye Jr

(Residence in Baltimore: No. 2115 Maryland Ave Life St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Child

6-DATE OF BIRTH, July 13/1916, (Month) (Day) (Year) 5 Yrs

7-AGE,	If LESS than 1 day,
4 yrs. 8 mos. ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto MD

PARENTS.

10-NAME OF FATHER, Charles E Dye

11-BIRTHPLACE OF FATHER (State or Country), Georgia

12-MAIDEN NAME OF MOTHER Lena Turner

13-BIRTHPLACE OF MOTHER (State or Country), Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Charles E Dye
(Informant)

2115 Maryland Ave
(Address)

15-JUL 17 1921 ROBERT I KRAUTER
Filed, 191. Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 15/21, (Month) (Day) 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries received from automobile accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner.)

July 16, 1921 (Address) 362 Rob Dunbar

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Jacksonville Fla.

DATE OF BURIAL, July 16/21 1921

20-UNDERTAKER, Williamcook

ADDRESS 502 E North

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

55399 D 55399

HEALTH DEPARTMENT—CITY OF BALTIMORE

55399 D 55399

CERTIFICATE OF DEATH.

56

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (alias) William C. Morton (Norman Randolph)

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond, Virginia

PARENTS

10 NAME OF FATHER William Morton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond, Virginia

12 MAIDEN NAME OF MOTHER Mary Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond, Virginia

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JUL 17 1921 ROBERT J. BRUTAN Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1921, to July 15, 1921.

that I last saw him alive on July 15, 1921.

and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) ——

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

7/15/21 Address New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond, Va.	July 17th 1921

20 UNDERTAKER ADDRESS

E. J. Fanning & Son, 1938 E. Lafayette Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55400

CERTIFICATE OF DEATH.

D 55400

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4th St. Cor 2nd Ave. Fairfield (ST.) 25 (WARD)

2-FULL NAME Rovirtie Shifflett

(a) RESIDENCE. (No.) 4th St. Cor 2nd Ave. ST., WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of James C. Shifflett

6 DATE OF BIRTH (month, day, and year) Apl. 15/1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife .037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Green Co., Va.

PARENTS

10 NAME OF FATHER C. T. Shifflett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Green Co. Va.

12 MAIDEN NAME OF MOTHER Maria H. Berry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rockingham Co. Va.

14 Informant J. C. Shifflett

(Address) 4th St. Cor 2nd Ave. Fairfield

15 Filed JUL 17 1921 ROBERT I. KRUTTER Registrar

Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1921, to July 15, 1921,

that I last saw h[illegible] alive on July 15, 1921,

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Acute Gastro enteritis

2 (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) do yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. T. Davis, M. D.

7/16, 1921 (Address) 211 Church St. Cville Va.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlottesville Va	July 17 1921

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55401

CERTIFICATE OF DEATH.

104 D 55401

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1208 N Caroline ST. 10 WARD)

2-FULL NAME Edward H Goldberg

(a) RESIDENCE. NO. 1208 N Caroline ST., WARD. 10th

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 17/920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ditto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER David Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie Goldstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rob Goldberg
(Address) 1208 N Caroline

15 Filed JUL 17 1921 ROBERT I. KRAMER Registrar
BURIAL PERMIT Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15 1921 to July 16 1921.

That I last saw him alive on July 15 1921.

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cholera infantum
Gastro enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Ruth Thomas M. D.

(Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt. Carmel	July 17 1921

20 UNDERTAKER Jacob Lewis, 1411 E. Baltimore ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than 1 day, so that it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55402

D 55402

RE[illegible]ERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1800 E. LaFayette Ave ST.: 64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis C: Hanselmann

(a) RESIDENCE. NO. 1800 E: LaFayette Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie M: Hanselmann

6 DATE OF BIRTH (month, day, and year) Sept 27th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer Retired 5 Yrs

045

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Hanselmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosina Eckhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marie M: Hanselmann
(Address) ~~1800 E: Lafayette Ave~~

15 Filed JUL 17 1921 [illegible] Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from December 15 1919, to July 14th 1921, that I last saw him alive on July 14 1921, and that death occurred, on the date stated above, at 8. P.M.

The CAUSE OF DEATH* was as follows:

Hemorhage of Brain
Cerebral Hemorhage
Secondary

Primary Hypertrophy of Heart (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Effects from a Nephritis (duration) 2 years mos. ds.

18 Where was disease contracted if not at place of death? N W. Cor Monument and Wolfe

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas J Simms, M. D.

, 19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Jul 18

20 UNDERTAKER John Henrich & Co ADDRESS 2008 Aliceanna

INSTRUCTIONS: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55403

CERTIFICATE OF DEATH.

120 ✓

D 55403

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2131 E. Chase ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Rebeca Gross

(a) RESIDENCE. NO. 2131 E. Chase St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Gross

6 DATE OF BIRTH (month, day, and year) Oct. 27, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Luzbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Lumpreck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Paul A. Gross 2131 E. Chase st

15 JUL 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 27 1920 to July 15 1921 that I last saw h[illegible] alive on July 14 1921 and that death occurred, on the date stated above, at 7.15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hy. Petterman, M. D.

, 19 (Address) 829 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 18th 1921

20 UNDERTAKER Henry Lutz ADDRESS 1007 Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55404

CERTIFICATE OF DEATH.

154

D 55404

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2320 Essex St. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Szulczewska

(a) RESIDENCE. NO. 2320 Essex St ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
(Husband of / Wife of) John Szulczewska

6 DATE OF BIRTH (month, day, and year) August 1 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER ~~###~~ Pietrzak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Szulczewski

(Address) 2320 Essex St

15 Filed JUL 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 9 19 21, to July 15 19 21

that I last saw her alive on July 15 19 21

and that death occurred, on the date stated above, at 9.45 a m.

The CAUSE OF DEATH* was as follows:

General collapse due to

weakened and aged condition, (duration) yr. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Oehlschlager M. D.

7/15, 1921 (Address) 2 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	July 18 1921

20 UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann St

CAUSE OF DEATH in plain terms, so that it may be understood by the public. Do not use abbreviations or technical terms. Omissions will be supplied by the Registrar. Statement of contributory cause of death is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Harry Lane.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55405

CERTIFICATE OF DEATH.

D 55405

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.) 8 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Lane

(a) RESIDENCE. No. 1313 N. Patterson Park Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Harry B Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUL 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1921, to July 16, 1921, that I last saw h... alive on July 16, 1921, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Indigestion

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) W. H. Davison M. D.

, 19 (Address) J H H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	July 18 '21
20 UNDERTAKER Robt. Turner & Son	ADDRESS 1818 E. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly coded on back of certificates. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55406

CERTIFICATE OF DEATH.

1920

D 55406

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO. 3022 Frestman ST.: 15 WARD)

2-FULL NAME Samuel Hays

(a) RESIDENCE. NO 3022 Freestman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE Clara M. Hays

6 DATE OF BIRTH (month, day, and year) 8. 27. 67.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Receiving Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Dry Goods.

(c) Name of employer Hutzler Bros. Balto.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward P. Hays

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Eldridge

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs. Clara M. Hays
(Address) 3022 Freestman st.

15 Filed JUL 17 1921, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7. 15. 1921.

17 I HEREBY CERTIFY, That I attended deceased from December 4 19 19, to July 15 19 21,

that I last saw him Alive on July 15 19 21.

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interst. Nephritis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

17 (Signed) Dr. Wm. H. A. Meyer, M. D.

16, 1921 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	7/18/21
20 UNDERTAKER	ADDRESS
H. E. Hughes	422 N. Broadway

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Physicians are required to report to the Health Department the existence of every case of communicable disease coming under their care, and to report the death of every person who has been under their professional care within twenty-four hours after death occurs. Undertakers are required to obtain a burial permit before burying the body of any person who has died in the City of Baltimore, and to deliver the certificate of death to the person issuing the burial permit. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55407 | 104 D 55407

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 S Bethel ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wieczslaus Borawski

(a) RESIDENCE. NO. 706 S Bethel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wotold Borowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josefine Sadkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Josephine Borowski 706 S Bethel St

15 Filed JUL 17 1921 ROBERT J KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1921, to July 16, 1921, that I last saw him alive on July 16, 1921, and that death occurred, on the date stated above, at 1120 A m.

The CAUSE OF DEATH* was as follows:

Acute Otitis Infantum

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Heat Exhaustion

Prostration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? None

What test confirmed diagnosis? —

(Signed) Joseph L. Valentine M. D.

7/16, 1921 (Address) 1 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	July 17 1921

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55408

~~B~~ 55408

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (ST.:) (WARD) 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Larkins

(a) RESIDENCE. NO. 516 N. Gonzales St. WARD,
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14—1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gang Shoveller

(b) General nature of industry, business, or establishment in which employed (or employer) 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland U. S.

PARENTS

10 NAME OF FATHER Patrick Larkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Sarah Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant (Address) Johns Hopkins Hospital Record

15 Filed JUL 17 1921 ROBERT J. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10— 1921 to July 15— 1921

that I last saw h~~im~~ alive on July 15— 1921

and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis, tuberculous

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~Home~~ Croup

Did an operation precede death? Yes Date of June 30th

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) C. R. Mason M. D.

7-16-, 19 (Address) 516 N. Gonzales

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Port News Va	7-17 1921
20 UNDERTAKER Sam'l W. Elcano Son	ADDRESS 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or initials. Do not write on back of certificates. TION is very important. See instructions on back.

(over see affadavit)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55409

CERTIFICATE OF DEATH.

1920 D 55409

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 728 Ensor street St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Freidman

(Residence in Baltimore: No. 3938 Reisterstown Road St.: 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) M

6-DATE OF BIRTH, Unkown (Month) ....., (Day) 1869 1877 (Year)

7-AGE, 52 44 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clothing
(b) General nature of industry, business, or establishment in which employed (or employer)..... Tailor

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unkown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unkown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levi's

(Address) 1411 E Baltimore St

15- Filed JUL 17 1921 191.....

ROBERT F KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 16 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Chronic Intestinal Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.)

7-17 1921 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, For Knen Cis Memorial

DATE OF BURIAL, July 17, 1921

20-UNDERTAKER Jack Levi's

ADDRESS 1411 E Baltimore St

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Baltimore, Md. August 2, 1921.

I do hereby make oath that the age given on Baltimore City Department of Health Certificate of Death No. D055409, as 44 years, is not correct, same should be recorded as 52 years. Name of deceased Samuel Freidman.

Jack Lewis

Subscribed and sworn to before me this 2d day of August, 1921

Rick Gaither

Notary Public.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55410

D 55410

CERTIFICATE OF DEATH.

104

D 55410

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2256 Cecil Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Regina Futsch

(Residence in Baltimore: No. 2256 Cecil ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Sngl

6-DATE OF BIRTH, Nov. (Month) 21 (Day), 1920 (Year)

7-AGE, ...yrs. 7 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, Edgar J Futsch

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Nellie Regina Fallon

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E Futsch

(Address) 2236 Cecil ave

15-

Filed JUL 17 1921 191.....

ROBERT I. KRAUTER
Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 16 1921, to July 16 1921, that I saw h.r alive on July 16 11 am 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) 48 hours mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Jno M Donaghue M. D.

July 17th, 1921. (Address) 1801 St. Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, July 7., 1921

UNDERTAKER E A Wendfeld

ADDRESS 501 E 21 St

MV 4568

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 55411

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Harris Ave. (Gardenville ST.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva. Walburga. Darney.

(a) RESIDENCE. No. 7 Harris Ave. (Gardenville) WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 22 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles. F. Darney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Dorothy Diller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr. Charles F. Darney
(Address) 7 Harris Ave. Govdenville

15 Filed JUL 17 1921 19 ROBERT J. KRAUTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-16-1921

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1921, to July 16, 1921, that I last saw h[illegible] alive on July 16, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

7 days (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Geo D Corbe, M. D.

, 19 (Address) Southern Ave Gardenville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Comety	July 18 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1301 E Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55412

CERTIFICATE OF DEATH.

120

D 55412

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. S.W. Cor Fulton Ave & Franklin ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Barton

(a) RESIDENCE. NO. Home for the Aged of the M.E. Ch. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 23, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 200

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer ~

9 BIRTHPLACE (city or town) (State or country) Delaware.

PARENTS

10 NAME OF FATHER Geo. Barton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary E Stoops

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant John C. Williamson

(Address) 2829 Harford Ave. [illegible] TRAUTE

15 Filed JUL 17 1921 Burial Permit Issued Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 16, 1921, to July 15, 1921, that I last saw h er alive on July 14, 1921, and that death occurred, on the date stated above, at 4.15 p m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 2 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) ~ yrs. 3 mos. ~ ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No. Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Ordinary Analysis.

(Signed) Geo. C. Shannon, M. D.

7/16 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Church Hill Cemetery Queen Anne Co	July 18 1921
20 UNDERTAKER Geo J Smith	ADDRESS 1000 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55413

HEALTH DEPARTMENT—CITY OF BALTIMORE

50-092
50 D 55413

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 S. Addison ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Wild

(a) RESIDENCE. NO. 110 S Addison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Augustus V. Wild

6 DATE OF BIRTH (month, day, and year) April 1 - 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry Eschbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Augustus V. Wild
(Address) 110 Addison st

15 Date JUL 17 1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15- 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. , 1920 , to 7/15/21 , 19 .

that I last saw her alive on 7/14/21 , 19 .

and that death occurred, on the date stated above, at 7 30 A. m

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Leonard J Fong , M. D.

7/15/1921 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 15 1921
20 UNDERTAKER	ADDRESS
George J Smith	Fayette st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55414

41 D 55414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE (No. Charles St 3 34 St S. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Mann

(a) RESIDENCE. No. Cambridge Apartments, Charles St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	1	15	

8 OCCUPATION OF DECEASED Manager

(a) Trade, profession or particular kind of work Iron & Steel Junk

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Jacob Mann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Julia Amey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs F M Bond
(Address) Pasadena Md daughter

15 Filed JUL 17 1921 LOWERY & KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to July 15, 1921, that I last saw h im alive on July 14, 1921, and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Colon -

(duration) yrs. 4+ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr 5 1921
no

Was there an autopsy?

What test confirmed diagnosis? Inspection at Operation

(Signed) Wm J. Watson, M. D.

July 9 1921 (Address) 2126 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 18 1921
20 UNDERTAKER Geo J Smith	ADDRESS 1000 N Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 55415 D 55415

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Bartlett Ave; 9 WARD) REGISTERED NO. 979

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Scally

(a) RESIDENCE. No. 718 Bartlett Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of Anne J. Scally

6 DATE OF BIRTH (month, day, and year) 6/7/1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	-70-	-1-	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Scally

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Covahy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Tom Scally (Address) 718 Bartlett Ave

15 Filed July 19 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 20th, 1921, to July 15th, 1921, that I last saw him alive on July 15th, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical symptoms

(Signed) L. M. C. Parker, M. D.

July 17th, 1921 (Address) 1114 Harpster

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Joseph Cem. Texas Md	7/18/21

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Hartford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificate is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 55416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55416

43

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1921 Harlem Ave ST., 16 WARD)

2-FULL NAME Alice S Collison

(a) RESIDENCE NO. 1921 Harlem Ave ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb-15-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	5	2.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Callison

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Talbot Md

12 MAIDEN NAME OF MOTHER E. R. Kone

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Miss Kate Callison
(Address) 1921 N. Harlem ave

15 Filed JUL 13 1921, 19 G. H. Cresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-17-1921

17 I HEREBY CERTIFY, That I attended deceased from June 6 ..., 1921 ..., to July 17 ..., 1921 ..., that I last saw he alive on July 16 ..., 1921 and that death occurred, on the date stated above, at 4. a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast with extension to stomach and liver.

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) General asthenia

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 26-1920

Was there an autopsy? No

What test confirmed diagnosis? Surgical & Clinical

(Signed) Worsley Cole M. D.

7/17 19 (Address) 2202 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL July 19 1921

20 UNDERTAKER Wm. Cook. ADDRESS 502 E. North Ave

mation should be carefully supplied. AGE should be stated in every case even if it may be properly classified. Exact statement of occupation is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is necessary. See Instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

55417

HEALTH DEPARTMENT—CITY OF BALTIMORE

55417

CERTIFICATE OF DEATH.

REGISTERED NO. C 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3702 Elm Ave ST.: V3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and NOT out No. 18.)

2-FULL NAME Unnamed infant son of Emory & Mary Markley

(Residence in Baltimore: No. 3702 Elm Ave St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	

6-DATE OF BIRTH. July (Month) 17 (Day), 1921 (Year)

7-AGE. ....yrs. ....mos. ....ds.

If LESS than 1 day. ....hrs. or 10 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——— None
(b) General nature of industry, business, or establishment in which employed (or employer) ———

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Emory Markley

11-BIRTHPLACE OF FATHER (State or Country). Balto Co Md

12-MAIDEN NAME OF MOTHER Mary Landrey

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Markley

(Address) 3702 Elm Ave

15-

Filed JUL 18 1921 191....

I. E. Wahal Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 5:40 1921, to July 17 5:40 1921, that I saw h[illegible] alive on July 17 1921, and that death occurred, on the date stated above, at 5:40 a m.

The CAUSE OF DEATH* was as follows:

Stillborn died antepartum
due to pressure on
the Cord (umbilical)

(Duration) ....yrs. ....mos. 1 ....ds.

CONTRIBUTORY (Secondary) Breech delivery

(Duration) ....yrs. ....mos. ....ds.

(Signed) S. K. Wantz M. D.

July 18, 1921 (Address) 865 N. Wolfe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Marys Hampden DATE OF BURIAL. July 18, 1921.

UNDERTAKER. Horace H. Burger ADDRESS 363 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55418 [redacted]

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55418

REGISTERED NO. C [redacted]

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1434 Covington ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Scally

(Residence in Baltimore: No. 1434 Covington St.: 45 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. July (Month) 16 (Day), 1876 (Year)

7-AGE. ....yrs. 45 mos. ....ds. If LESS than 1 day, ...hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Farm

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Francis Scally

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Ellen Flynn

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank E. Scally

(Address) 1434 Covington St.

15- Filed ....., 191.... G. H. Griese, Registrar.

JUL 18 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 16 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 191 , to — 191 , that I saw h im alive on July 16 1921 , and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy Labor 30 Yrs
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Hypertrophy Labor 7 Yrs
(Duration) ....yrs. ....mos. ....ds.

(Signed) Robt. B. C. Lehnert M. D.

July 17, 1921. (Address) 1318 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Cathedral Cem. DATE OF BURIAL. July 18 1921

20-UNDERTAKER Margaret D. Flynn ADDRESS 1 Fox Lyle St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55419

CERTIFICATE OF DEATH.

1054

D 55419

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 Biddle St.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Shipley

(Residence in Baltimore: No. 307 Biddle St.; 5yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Color

5-SINGLE, MARRIED, WIDOW'ED OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. Unknown, 1 (Month) (Day) (Year)

7-AGE. 6 V yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer). Private

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Mont-Mollis,

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Susan Brand

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Bell

(Address) 307 Biddle St.

15-

Filed JUL 18 1921, 191.... I. E. Wohl Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July 16th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 8th 1921, to July 16th 1921, that I saw h[illegible] alive on July 16th 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis entero

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Stomach trouble

(Duration) 5 yrs. mos. ds.

(Signed) A. Lee Lohr M. D.

7/16, 1921 (Address) 724 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cem. DATE OF BURIAL. July 18, 1921

20-UNDERTAKER James F. Lewis ADDRESS 1303 Russ St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55420 — 1041 D 55420

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 27 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Kunzelmann

(a) RESIDENCE. No. 5019 Park Heights Av St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Whit	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 29 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Kunzelmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Rosa Koelic

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant John Kunzelmann (Address) 5019 Park Heights Av

15 Filed JUL 18 1921, 19.... E. M. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1921, to July 17, 1921, that I last saw him alive on July 17, 1921, and that death occurred, on the date stated above, at 9.30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Indigestion

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) None

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. C. Davison, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	July 19th 1921
20 UNDERTAKER Frank Lassahn & Sons	ADDRESS Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55421

CERTIFICATE OF DEATH.

D 55421

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hos ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William E. Cookson

(a) RESIDENCE. NO. Brooklyn ade. Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. William Cookson.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Alto Thomas

(c) Name of employer Alt. Thomas

9 BIRTHPLACE (city or town) (State or country) Chester. S. Carolina

PARENTS

10 NAME OF FATHER William Cookson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y. N. Y.

12 MAIDEN NAME OF MOTHER Lizzie Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant Mrs. Mamie Cookson (Address) Brooklandville Balto Co. Md

15 Filed ..., 19... Registrar

JUL 18 1921 G. H. Cross

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1921, to July 17, 1921, that I last saw h... alive on July 17, 1921, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Tetanus.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Sepsis. Railroad accident 4 weeks ago (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 16 - 21

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) N. W. Sammons, M. D.

July 17 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem Cem. Balto	July 22
20 UNDERTAKER	ADDRESS
John Burns Sons	Toronto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55422

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55422

CERTIFICATE OF DEATH.

109

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital St.. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Hunt

(a) RESIDENCE. No. 1607 W. Mulberry ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1st 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Boker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Harriet Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Daniel Hunt
(Address) 1607 W. Mulberry St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1921

17

I HEREBY CERTIFY, That I attended deceased from July 17 , 1921 , to July 16 , 1921 , that I last saw h er alive on July 16 , 1921 , and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Operation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Post-operative pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-11-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard M. Bulent , M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Laurel — DATE OF BURIAL July 19 1921

20 UNDERTAKER John H. Tradin — ADDRESS 142 Ostend St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of personsengaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Strangulated Hernia x
Cystic Ovary

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55423 — 91 D 55423

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (NO. 904 N. Payson St. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Arthur Pruitt Jr.

(a) RESIDENCE. NO. 904 N. Payson ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 10th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Herbert A. Pruitt

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret M. Griffith

13 BIRTHPLACE OF MOTHER (city or town) W. Va.
(State or country)

14 Informant Herbert A. Pruitt Sr.
(Address) 904 N. Payson St.

15 Filed 19
18197 I. F. Wohn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12 . 1921 . to July 16 . 1921 .
that I last saw him alive on July 16 . 1921 .
and that death occurred, on the date stated above, at 12.10 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia
Wh
(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? ✓ Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) E Keller Hamming M. D.
7/18. 1921 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 19th. 1921
20 UNDERTAKER	ADDRESS
J. Putnam Bond	1723 N. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55424.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55424

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 232 E. Montgomery (ST.) 229 (WARD)

2-FULL NAME Winfield Scott Tull

(a) RESIDENCE. NO. 232 E. Monigomery ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth S. Tull

6 DATE OF BIRTH (month, day, and year) June 5th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Mariner 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Worcester Co. Md.

PARENTS

10 NAME OF FATHER Benjamin Tull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Merrill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

11 Informant Elizabeth S. Tull
(Address) 232 E. Montgomery St.

15 Filed ..., 19... Registrar

I. E. Wohl

JUL 18 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1921

17 I HEREBY CERTIFY, That I attended deceased from July 9th, 1921, to July 16, 1921, that I last saw h~~im~~ alive on July 15th, 1921, and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:

Heart Disease

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Harry Goldberg, M. D.

7/18 1921 (Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL July 19 1921

20 UNDERTAKER John F. Denny — ADDRESS 755 Light

Information should be given in plain terms, so that it may be properly classified. Each statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55425

CERTIFICATE OF DEATH.

1688

D 55425

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) So Balto., Gen Hosp (WARD) 18

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mayers

(a) RESIDENCE. NO. 928 W Pratt ST., WARD. Balto Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wh	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10 - 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Michael Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Alice Kranny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Radcliff

(Address) 928 W. Pratt St

15 Filed JUL 18 1921 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 - 1921

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1921, to July 16, 1921, that I last saw h.. alive on July 16, 1921, and that death occurred, on the date stated above, at 330 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis and acute peritonitis.

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Cost Opr Ileus 24 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 29 - 1921

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R W Johnson, M. D.

, 19 (Address) So Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	July 19 1921

20 UNDERTAKER ADDRESS

John J Fields 1200 N Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 1 ✓

D 55426

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2543 Pennsylvania Ave ST.; 43 WARD)

2-FULL NAME Frank L. Reamer

(a) RESIDENCE. NO. 2543 Pennsylvania Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor Reamer

6 DATE OF BIRTH (month, day, and year) Oct 28. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Wm M. Reamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Abbie Mann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eleanor Reamer

(Address) 2543 Pennsylvania ave

15 Filed JUL 19 1921 19 I. E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 16 . 1921 . to July 17 . 1921 .

That I last saw h in alive on July 16, . 1921 .

and that death occurred, on the date stated above, at 1030A m.

The CAUSE OF DEATH* was as follows:

The Tumor of

Intris-Silvis

Malformation (duration) yrs. 68 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Lu Davis, M. D.

. 19 (Address) 847 N. Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL July 19 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No Harmonbaye

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55427

CERTIFICATE OF DEATH.

D 55427

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 Webster ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebina Armstrong Roberts

(a) RESIDENCE. NO. 1610 Webster ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. Roberts

6 DATE OF BIRTH (month, day, and year) 1868. 4. 3

7 AGE 53 Years 3 Months 13 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Belfast Ireland.

PARENTS

10 NAME OF FATHER Armstrong

11 BIRTHPLACE OF FATHER (city or town) Belfast (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Belfast (State or country) Ireland

14 Informant Edwin Roberts (Address) 1610 Webster St

15 JUL 18 1921 C. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7, 16 1921

17 I HEREBY CERTIFY, That I attended deceased from 7 5 1920, to 7.16 1921,

that I last saw her alive on 7.16 1921,

and that death occurred, on the date stated above, at 11.05 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus
Abdominal Viscera

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) L. J. Burlington, M. D.

7.6 1921 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	7/19 1921
20 UNDERTAKER	ADDRESS
L. Fen McCully	130 E Fort

mation should be properly classified. Full name should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Full name should be given. TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55428 H. Gresed

CERTIFICATE OF DEATH.

X 40 D 55428

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Harry Hunter

(a) RESIDENCE. NO. Benson, Harford Co, Md ST., ... WARD. Benson Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs ..... mos ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 20, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	10	27	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Seattle, Wash.

PARENTS

10 NAME OF FATHER Walter Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant C. E. Hornberger

(Address) Fallston Md.

15 Filed JUL 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 16 1921, to July 17 1921, that I last saw him alive on July 17 1921, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Tumor of liver (Sarcoma?)
Ascites
Emaciation.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Benson, Md

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) L. H. Tannenbaum, M. D.

July 17 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fallston Md — DATE OF BURIAL: July 9 1921

20 UNDERTAKER: Wm J Tuckerman Sons — ADDRESS: North Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55429

64091

D 55429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.: [illegible] WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Krumenas

(a) RESIDENCE. No. 804 W Pratt St ST., ... WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 7 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1853

7 AGE 68 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Mateus Krumenas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Catorin Rochis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Hosp. Rec'd (Address) New City Hosp.

15 Filed ..... 19 ..... Registrar

JUL 18 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-16 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-8 1921 to 7-16 1921

that I last saw him alive on 7-16 1921,

and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? 804 W Pratt St

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

19 (Address) New City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 19 1921

20 UNDERTAKER ..... ADDRESS John Grehlinger 425 S. Pac

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should have CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55430

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55430

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 W Saratoga St. WARD 4)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Prottire

(a) RESIDENCE. NO. 618 W Saratoga ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 10 months How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) July 18-24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General natore of indostry, bosiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Pasquale Prottire

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Jessie Cherrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Pasquale Prottire
(Address) 618 W Saratoga

15 Date JUL 18 1924 Registrar I. R. Wehn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 19 24

17

I HEREBY CERTIFY, That I attended deceased from July 18, 19 24, to July 18, 19 24

that I last saw h.. alive on July 18, 19 24,

and that death occurred, on the date stated above, at 8:25 a.m.

The CAUSE OF DEATH* was as follows: Abnormal delivery

Immature premature

Strangulation in Cord (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. L. Valentine M.D.

(Address) 2 E. Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	July 18 1924
20 UNDERTAKER	ADDRESS
Wendell Pfeffelsdorf	373 Lem

INSTRUCTIONS.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular to have CAUSE OF DEATH properly classified. Exact statement of OCCUPATION should be given in all certificates. See instructions on back of certificate. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1494 D 55431 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55437

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital (St.: 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Dyfreccio

(a) RESIDENCE. No. 1624 Gartuchaz. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Dyfreccio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Plummer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed ....., 19 .... L. E. Webb Registrar

JUL 18 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17- 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15-, 1921, to July 17, 1921, that I last saw h.. alive on July 17, 1921, and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Indigestion

(duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) W. Dawson, M. D.

19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	July 19 1921
20 UNDERTAKER	ADDRESS
Wendelbo Dyfreccio	378 N

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55432 — 9M D 55432

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Rada

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed JUL 18 1921 19 L. E. Wehrl Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1921

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1919, to July 16, 1921, that I last saw him alive on July 15, 1921, and that death occurred, on the date stated above, at 6:45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? yes.

(Signed) Alfred O'Neill, M. D.

7/16/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Stainsfous Crem.	July 18 1921.
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	705 S. Ann St

mation should be carefully supplied. Age should be stated EXACTLY. Exact statement of OCCUPA-
be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55433 — 152 — D 55433

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Cor W & C 1st ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Fisher

(a) RESIDENCE. NO. 712 Cor W & C 1st ST., WARD.
(Usual place of above) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 15 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Ira Leonard Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore.

12 MAIDEN NAME OF MOTHER Hallie Pearl Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Ira Leonard Fisher
(Address) 712 Cor W & C 1st

15 Filed JUL 18 1921 19 C. H. Cress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 17 1921, to July 17 1921, that I last saw him alive on July 17 1921, and that death occurred, on the date stated above, at 3.17 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dover

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Dr. J. Tillett M. D.

(1921) (Address) 712 Cor W & C 1st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	July 19 1921

20 UNDERTAKER Chenoweth Son ADDRESS Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55434

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55434

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 S. Gilmor ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolores A. Lowman

(a) RESIDENCE. NO. 132 S. Gilmor ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 15 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Ira Lowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Healy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Ira Lowman
(Address) 132 S Gilmor st

15 Filed JUL 19 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15 1921, to July 17 1921, that I last saw her alive on July 17 1921, and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, following acute enteritis

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Diarrhea

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Carcinoma of rectum

(Signed) C. J. Gump M. D.

, 19 (Address) 6100 Dartmouth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	July 19 1921.
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 55435

D 55435

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 646 S. 14th ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ruth Crist

(a) RESIDENCE. No. 646 S. 14th ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Harry Crist

6 DATE OF BIRTH (month, day, and year): Feb 28-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer): (none at home)

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Wodegraff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Isabella Dyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mrs. John Dudley (Address) 646 S. 14th St.

15 Filed JUL 18 1921 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15 1921

17

I HEREBY CERTIFY, That I attended deceased from June, 1921, to July 15, 1921.

that I last saw h.. alive on July 14, 1921.

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma 'rt tibia

(duration) (estimated) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (+ Toxemia) general exhaustion

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? St. Joseph's Hospital Lab.

(Signed) W. W. Rangeley, M. D.

July 17 1921 (Address) 1014 S. Belnord Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel — DATE OF BURIAL: July 19 1921

20 UNDERTAKER: William G. Schnepf — ADDRESS: 816 Mount

Grese.

IMPORTANT. Exact statement of OCCUPATION may be properly required. Exact statement of OCCUPATION in plain terms, so that it may be properly coded. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 55436

CERTIFICATE OF DEATH.

28 D 55436

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 819 McDonough ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Sharp Glenn

(a) RESIDENCE. NO. 819 McDonough ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
31				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) live in Balt 2 years S. C

PARENTS

10 NAME OF FATHER Jessie Pernell

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Lizzie Marlay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Pearl Johnson
(Address) 819 McDonough St

15 Filed JUL 18 1921 LOWELL J. CHAUTEN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17

I HEREBY CERTIFY, That I attended deceased from June 3, 1921, to July 17, 1921, that I last saw h[illegible] alive on July 13, 1921, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

7-18 1921 (Address) 822 N. Bond St

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salem Station

DATE OF BURIAL July 19 1921

20 UNDERTAKER Morrison & Co

ADDRESS 1725 Ashland Ave

Mrs Robert A Elliott

Burial Permit Clerk

mation should be carefully supplied. Any [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 55437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55437

CERTIFICATE OF DEATH. + 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Ensor ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Martin

(a) RESIDENCE NO. 1718 Artic ave Atlantic City N.J. ST., WARD Atlantic City

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colord

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced WIFE of HUSBAND of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 74 Years — Months — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lie in Ball - 4 months Lou in Va

PARENTS

10 NAME OF FATHER Per A L Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia N J

12 MAIDEN NAME OF MOTHER Martha Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Martha Martin (Address) Atlantic City N J

15 Filed JUL 18 1921 19 Burial Permit Issued Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5 1921 to July 18 1921 that I last saw her alive on July 18 1921 and that death occurred, on the date stated above, at 12.45 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Bright Disease +

Paralysis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Paralysis + Chronic Bright Disease (duration) 1 yrs. 7 mos. 12 ds.

18 Where was disease contracted if not at place of death? Atlantic City N.J.

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D G W Kennard M. D.

7-18 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Atlantic City N J — DATE OF BURIAL July 18 1921

20 UNDERTAKER Wm R A Elliott — ADDRESS 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Erasures or alterations CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—8-24-14—M. & T.—2000 Bks.

D 55438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55438

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 903 Cold Spg. Lane ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Anthon

(Residence in Baltimore: No. 903 Cold Spg. Lane St.: 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. April 26, 1847
(Month) (Day) (Year)

7-AGE. 74 yrs. 2 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Odd

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. John Anthon

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER. Susan Gregsby

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Edward Heath

(Address) 903 Cold Spg. Lane

15-

Filed JUL 18 1921 191.... ROBERT J. KRAUTER Registrar.

Burial permit issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July 17, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1921, to July 17 1921, that I saw him alive on July 16 1921, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Uraemia & Gleason's ?
Chronic Myocarditis
Contributory Myocardial insufficiency (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. 2 ds.

(Signed) [illegible] M. D.

July 11, 1921 (Address) 3429 Clifton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Mary's Stamford — DATE OF BURIAL. July 19, 1921

20-UNDERTAKER H. J. Marshall — ADDRESS 353 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55439

CERTIFICATE OF DEATH.

28 D 55439

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tb Hosp. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Davis

(a) RESIDENCE. NO. 308 Pine st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred W yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26		/	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Stevedore 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Joseph Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. C.

12 MAIDEN NAME OF MOTHER Rose Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. C.

14 Informant

(Address)

Filed JUL 18 1921 ROBERT I. KRAUTZ Registrar

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1921

17 I HEREBY CERTIFY, That I attended deceased from June 8th 1921 to July 14 1921 that I last saw h in alive on July 14 1921 and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tb.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tb. bac in sputum

(Signed) [illegible] M. D.

. 19 (Address) Mun City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND. DATE OF BURIAL

20 UNDERTAKER ADDRESS JUL 18 1921

Deputy Health Commissioner

mation should be carefully supplied. Age should be given in years, months and days if under one year. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55440

151 D 55440

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1195 N Fulton Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johanna McGeary

(Residence in Baltimore: No. 1195 N Fulton Ave St.; ....yrs.. ....mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. July (Month) 15 (Day), 1921 (Year)

7-AGE, ...yrs. ....mos. ....da. If LESS than 1 day, 6 hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓ None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Chas McGeary

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Margaret Stanatury

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas McGeary

(Address) 1195 N Fulton Ave

15- JUL 18 1921 Filed....., 191.... JOHNS HOPKINS HOSPITAL Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 15 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1921, to July 15 1921, that I saw h-- alive on July 15 1921, and that death occurred, on the date stated above, at 3P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

Life

(Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....da.

(Signed) Ralph L Trogt M. D.

7/15, 191.. (Address) 26 E Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner of Health,

ADDRESS JUL 19 192

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION always important. See instructions on back of certificate.

Spec.—6-9-19—R. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 v

D 55441 REGISTERED NO. D 55441

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3443 Jenkins Avenue ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret R.Madigan

(a) RESIDENCE. NO. 3443 Jenkins Avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of * * *

6 DATE OF BIRTH (month, day, and year) Sept 25-1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Straw Hat Business

(c) Name of employer Towsend-Grace Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank X.Madigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ella V.Egan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Ella V.Egan
(Address) 3443 Jenkins Avenue

15 Filed JUL 18 1921 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 19 21

I HEREBY CERTIFY, That I attended deceased from July 3 19 21, to July 17 19 21, that I last saw h alive on July 16 19 21, and that death occurred, on the date stated above at 4 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Brown M. D.

7/18 19 21 (Address) 4132 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery.	July 20 19 21
20 UNDERTAKER	ADDRESS
Chas.F.Evans & Son	115 W.Mt. Royal Ave

ROBERT I. KRAUTER

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55442

CERTIFICATE OF DEATH.

64 ✓ D 55442

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2526 Mosher ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Solomon

(a) RESIDENCE. NO. 2526 Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Charles Solomon.

6 DATE OF BIRTH (month, day, and year) August 25-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	22 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caterer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Club

(c) Name of employer 20th century Club.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Philip Solomon.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Theresa Schwartzkopf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Isaac Solomon.
(Address) 2843 Woodbrook Ave.

15 Filed JUL 18 1921 19 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-11- , 1921 , to 7-17- , 1921 .
that I last saw her alive on 7-16- , 1921 .
and that death occurred, on the date stated above, at 11:05 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage.

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) High Blood Pressure.
(duration) unknown. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none needed.

(Signed) Chester Riland., M. D.

7-17, 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Hebrew Greenship 7/19/21

20 UNDERTAKER — ADDRESS

Chas. D. Evans & Son
118 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

55443

HEALTH DEPARTMENT—CITY OF BALTIMORE

55443

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 Watson ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Pitts

(a) RESIDENCE No. 1105 Watson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 20 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Pitts

11 BIRTHPLACE OF FATHER (city or town) City of (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Lillie Cooper

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Arthur Pitts (Address) 1103 Watson St.

15 Filed JUL 18 1921, 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18-1921

17 I HEREBY CERTIFY, That I attended deceased from July 13-, 1921, to July 18-, 1921, that I last saw him alive on July 17-, 1921 and that death occurred, on the date stated above, at 10.15 A m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cholera Infantum + Heat (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. W. Kennard, M. D.

7-18. 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	July 18 1921

20 UNDERTAKER Harry A. Vodery ADDRESS 1723 Orleans

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Graw

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55444

CERTIFICATE OF DEATH.

170

D 55444

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2325 E. Federal ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Konrad Graw

(a) RESIDENCE. No. 2325 E Federal ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Sophia Graw

6 DATE OF BIRTH (month, day, and year) Jan 29 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Soldier

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Balthazer Graw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Zeber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Henry Graw 1515 N Montford Ave

15 Filed JUL 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4 1921 to July 17 1921

that I last saw him alive on July 16 1921

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 1 yrs. mos. ds.

Pulmonary Oedema

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Leary M. D.

7/18 1921 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	July 19 1921
20 UNDERTAKER	ADDRESS
Wilbur M Shriver	1018 Edmondson Ave

N. B. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55445

CERTIFICATE OF DEATH.

X 176

1-PLACE OF DEATH Pronounced dead at 75 REGISTERED NO. C

CITY OF BALTIMORE (No. St. Agnes Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter E Lang

(Residence in Baltimore: No. Catonsville Md St.; yrs. 11 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Mal	white	Sing'l

6-DATE OF BIRTH, Dec 20, 1909
(Month) (Day) (Year)

7-AGE, 11 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Walter B Lang

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Fannie E Hammond

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter B Lang

(Address) Eleen Alpine Catonsville Md

15- JUL 18 1921 Filed....., 191.... ROBERT I KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 17, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Fracture Base of Skull
Internal Injuries
Shock & Cerebral Hemorrhage
Accident (Duration) Few hours ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) James H. Pentz M. D.
(Coroner.)
July 17, 1921. (Address) 700 E Chase St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem Bay	July 19, 1921
20-UNDERTAKER Geo J Smith	ADDRESS 1000 Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55446

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55446

CERTIFICATE OF DEATH.

15 - 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 62 Burrus Court Road ST.; 15 WARD)

2-FULL NAME Jeannette Christine Eisenbrandt

(a) RESIDENCE. No. 62 Burrus Court Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Henry Raphael Alexander Smith

6 DATE OF BIRTH (month, day, and year) June 8 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Georg Wild

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Schaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edw. Eisenbrandt

(Address) 62 Burrus Court Road

15 Filed JUL 18 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1921, to July 17, 1921.

that I last saw her alive on July 16, 1921.

and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis - Myocarditis, Chronic interstitial nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, senile debility

Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) W. S. Tublett, M. D.

July 19, 1921 (Address) 929 W Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 18 1921
20 UNDERTAKER	ADDRESS
H. Buckmeier Sons	Home Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's name
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55447

CERTIFICATE OF DEATH.

91

D 55447

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. (Gilman Apartment) Calvert & 31st. ST. ST.: 12 WARD)

2-FULL NAME Rev George Washington Gallagher

(a) RESIDENCE. NO. Gilman Apt. Calvert & 31st ST. 12 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 11 mos. ds. How long in U. S., if of foreign birth? 72 yrs. 5 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma.A.Gallagher

6 DATE OF BIRTH (month, day, and year) Jan. 25-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 6/18

(b) General nature of industry, business, or establishment in which employed (or employer) Presbyterian Min.

(c) Name of employer

9 BIRTHPLACE (city or town) Peekskill
(State or country) New York

PARENTS

10 NAME OF FATHER Joseph Gallagher

11 BIRTHPLACE OF FATHER (city or town) Donegal
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mullen

13 BIRTHPLACE OF MOTHER (city or town) Ballyclare
(State or country) Ireland

14 Informant Katharine.J.Gallagher (Daughter)
(Address) Gilman Apt. Calvert & 31 st ST

15 Filed JUL 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1920, to July 19, 1921, that I last saw him alive on July 17, 1921, and that death occurred, on the date stated above, at 9.45 a m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia with embolism at end.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Previous apoplexy with hemiplegia (duration) 6 yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? physical examination

(Signed) H. C. Marcel, M. D.

, 19 (Address) 3311 Abell Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bay Shore Long Island-New York	July 20 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 188 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55448

CERTIFICATE OF DEATH.

D 55448

1-PLACE OF DEATH US. PHS Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore St. Md. 24 WARD)

REGISTERED NO. 48 D 55448

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smiglewski

(a) RESIDENCE NO. US. PHS Hosp. #56 Fort McHenry ST. Baltimore WARD Md.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) ----

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
18 yrs	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER ----

11 BIRTHPLACE OF FATHER (city or town) (State or country) ----

12 MAIDEN NAME OF MOTHER ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ----

14 Informant Edgar T Rosenbrock Registrar
(Address) US PHS Hosp. #56 Ft McHenry Md

15 Filed JUL 18 1921 ROBERT T [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18/21 19

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19 , 1921 , to July 18 , 1921 .

that I last saw him alive on July 18 , 1921 ,

and that death occurred, on the date stated above, at 11'30 A.M.

The CAUSE OF DEATH* was as follows:

Arthritis chronic

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Dilatation acute cardiac

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas P. Payne M. D.
Senior Surgeon (R
, 19 (Address) US.PHS Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus — DATE OF BURIAL July 21 1921

20 UNDERTAKER John A Weber — ADDRESS 1803 Bank

N. B.—WHITE PAPER, WITH BLACK INK ONLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55449

CERTIFICATE OF DEATH.

D 55449

REGISTERED NO. 1044

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 416 S Regester ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genowefa Sliwka

(a) RESIDENCE. NO. 416 S Regester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 11 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER aleksander Sliwka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER anna Walinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant aleksander Sliwka
(Address) 416 S Regester

15 Filed JUL 18 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1921, to July 17, 1921, that I last saw h[illegible] alive on July 17, 1921, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Ecto Colitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Kennedy M. D.

19 (Address) 1801 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 19 1921

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

N. B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55450

CERTIFICATE OF DEATH.

61

D 55450

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 S Ann ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph I Sulewski

(a) RESIDENCE. NO. 518 S Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 5 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None dw

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Sulewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Jaglewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Sulewski
(Address) 518 S Ann

15 JUL 18 1921 Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from July 16 21, to July 18 21,
that I last saw h alive on July 18 21,
and that death occurred, on the date stated above, at 1120 A.m.

The CAUSE OF DEATH* was as follows:

Meningitis 3 d

CONTRIBUTORY (Secondary) Cardiac Pericarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) William H Sonnenburg M.D.

19 (Address) 801 N Decatur

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 19 1921

20 UNDERTAKER John M Weber ADDRESS 1803 Bank

A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55451

91-19

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2214 Eager Place ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelbert W. Raborg

(a) RESIDENCE. NO. 2214 Eager Place ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 27th 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Milton Raborg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Marie Bright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Marie Bright
(Address) 2214 Eager Place

15 JUL 19 1921 ROBERT I. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from April 30 1921 to July 17 1921.

that I last saw him alive on July 17 1921.

and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Acute Influenza

(duration) yrs. 2 mos. 18 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. B. Kleiphus Jun. M. D.

July 18 1921 (Address) 83 & 2 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery	July 20 1921
20 UNDERTAKER Henry Lutz	ADDRESS 1007 Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS STATISTICAL MATERIAL. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D 55452

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 S. Paca St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Benson.

(a) RESIDENCE. No. 1011 S Paca St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 11th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William E. Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ida C. Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant William E Benson
(Address) 1011 Paca St

15 JUL 19 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18 1921

17 I HEREBY CERTIFY, That I attended deceased from 7/17/21, 19, to 7/18/21, 19,
that I last saw him alive on 7/18/21, 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hemorrhage of Lungs

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thopkins Davis, M. D.

, 19 (Address) 1701 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: July 19 19

20 UNDERTAKER: John J. Cowan & Son — ADDRESS: 901 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55453

CERTIFICATE OF DEATH.

70 ✓

D 55453

REGISTERED NO.....

1-PLACE OF DEATH 211 N Schroeder

CITY OF BALTIMORE: (No George Cornish ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Cornish

(a) RESIDENCE. NO. 211 N Schroeder ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coachman

(b) General nature of industry, business, or establishment in which employed (or employer) Coachman O'D

(c) Name of employer W C Diffle Balto city

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Kate Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Kate Cornish (Address) 211 N Schroeder St

15 Filed JUL 19 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1. 1921. to July 16. 1921.

that I last saw h[illegible] alive on July 16. 1921.

and that death occurred, on the date stated above, at 1. 15 P m.

The CAUSE OF DEATH* was as follows:

Pyo-Hemalocele & Chest (Septicemia)

OVW

(duration) yrs. 3½ mos. ds.

CONTRIBUTORY (Secondary) mitral Insufficiency

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J Edward Fisher M. D

7-16-1921 (Address) 1612 E monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 19 1921

20 UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Kicked by horse four yrs. ago.

Dupt John & Annie Hopkins

Spec.—6-9-19—H. P. Co.—1000 Blks.

149194

D 55454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 ✓ D 55454

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Girl Hopkins

(a) RESIDENCE NO. 903 McDonough St ST., WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29- 21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer —

9 BIRTHPLACE (city or town) born in Baltimore
(State or country) born in Baltimore

PARENTS

10 NAME OF FATHER John Hopkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Steer

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D.C.

14 Informant: Annie Hopkins
(Address) 903 McDonough St

15 Filed ....., 19.... [illegible] KRAUTER
Registrar
[illegible] Record Clerk

JUL 19 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1921

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1921, to July 7, 1921, that I last saw h.. alive on July 7, 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: July 19. 1921

20 UNDERTAKER: Mrs Robert A Elliott — ADDRESS: 1725 Oakland Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S name and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55455

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Frederick Montgomery

(a) RESIDENCE. NO. 522 Arabian Place ST. Washington WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proof Reader

(b) General nature of industry, business, or establishment in which employed (or employer) O&b

(c) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) D.C.

PARENTS

10 NAME OF FATHER Jno. Montgomery

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary C. Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant Kept Record
(Address)

15 Filed JUL 19 1921 MONEY E. KRAUTER Registrar
Social Small Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1921, to July 18, 1921, that I last saw him alive on July 18, 1921, and that death occurred, on the date stated above, at 7:55 P. m.

The CAUSE OF DEATH* was as follows:

Basilar meningitis

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Chronic - 7 hrs 55

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? yes Date of July 18 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John J Brown, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D C	7/19/21

20 UNDERTAKER George A Farley ADDRESS Fulton & Fayette

N. B.—WHITE PLAINLY. WITH INDELIBLE PENCIL. Every question on this certificate should be carefully answered. If unknown, a reasonable effort should be made to obtain the information. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55456

CERTIFICATE OF DEATH.

31 D 55456

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 John St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Linton Graham

(a) RESIDENCE. No. 1511 John St., 14 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Augustus Graham

6 DATE OF BIRTH (month, day, and year) Sept. 18, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newtown, Pa.

PARENTS

10 NAME OF FATHER Robert Y. Linton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Newtown, Pa

12 MAIDEN NAME OF MOTHER Elma P. Yardley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Edgewood, Pa.

14 Informant Elma P. Graham
(Address) 1511 John Street

15 Filed JUL 19 1921 [redacted] Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1921, to July 18, 1921, that I last saw her alive on July 18, 1921, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pettigan, M. D.

, 19 (Address) 829 Hamilton Terr.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newtown - Bucks Co. Pa.	7-20 1921
20 UNDERTAKER Emory W. Jenkins & Sons Co	ADDRESS 1420 Linden Ave. Orchard.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55457 REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N. Caroline ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Rosenberg

(a) RESIDENCE. No. 217 N. Caroline St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Freida

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Romania

PARENTS

10 NAME OF FATHER Samuel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Roumania

12 MAIDEN NAME OF MOTHER Sara Mollie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Roumania

14 Informant (Address) J. Lewis 1411 E. Balto St.

15 Filed JUL 19 1921 19 [illegible] Registrar

Burial Permit Dept

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1921, to July 18, 1921, that I last saw h... alive on July 18, 1921, and that death occurred, on the date stated above, at 1 30 p. m.

The CAUSE OF DEATH* was as follows:

Senility

Other causes not determined

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not determinable

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Age

(Signed) Harry Finkelstein, M. D.

, 19 (Address) 14 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew North Point Road	7-19 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55458

D 55458

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Harley ave ST.; 9 WARD)

2-FULL NAME Carroll L. Zinck

(a) RESIDENCE. NO. 1416 Harley ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~~~~~~~~~

6 DATE OF BIRTH (month, day, and year) June 13th 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William C Zinck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Katherine Heck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) William C Heck 1416 Harley ave

15 Filed JUL 19 1921 ROBERT E. SLATER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1921, to July 18, 1921, that I last saw him alive on July 16, 1921, and that death occurred, on the date stated above, at 4.15 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope
Hard 4 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation of Heart (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. Latrobe Ewell M. D.

7/19. 1921 (Address) 905 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 21st 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55459 D 554

CERTIFICATE OF DEATH. REGISTERED NO. C

1-PLACE OF DEATH (If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. Ch P.S. Mansville Invalid Home near Prog St ST.: 4 WARD)

2-FULL NAME Thorvald Jacobsen

(Residence in Baltimore: No. — St.; yrs., mos. 11 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 6, (Month) (Day) 1877 (Year)

7-AGE, 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): boat

9-BIRTHPLACE. (State or Country), Norway

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country). Police Dept.

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Morgan Mc Cann

(Address) 19 South St

15- JUL 19 1921 191 ROBERT I KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 17, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pernicious Malaria

11 days

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. ds.

(Signed) H. J. Feely M. D. (Coroner)

July 18, 1921 (Address) 1037 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery DATE OF BURIAL, July 19 1921

20-UNDERTAKER Robt E Turner ADDRESS 1424 Bway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55460

CERTIFICATE OF DEATH.

1921

D 55460

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 Whitelock St. ST.) 13 WARD)

2-FULL NAME Margaret Elizabeth Applegarth

(a) RESIDENCE. NO. 808 Whitelock ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm W. Applegarth

6 DATE OF BIRTH (month, day, and year) May 4, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER W. M. Macculloch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Annie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Geo. H. Gore 1067 Cathedral St.

15 Filed JUL 19 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to July 18, 1921, that I last saw her alive on July 18, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis 4

(duration) 20 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial Dilatation

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Geo. H. Gore, M. D.

. 19 (Address) 1067 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	July 19 1921
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E. Nath ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Exner.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55461

CERTIFICATE OF DEATH.

REGISTERED NO. 79 D 55461

D 55461

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 W. Fayette ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Exner,

(a) RESIDENCE. NO. 1714 W. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? 74 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Exner

6 DATE OF BIRTH (month, day, and year) Aug. 24-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner Ret'd

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Exner, (Wife)

(Address) 1714 W. Fayette St.

15 Filed JUL 19 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 19 21

17 I HEREBY CERTIFY, That I attended deceased from May 10, 19 20, to July 18, 19 21, that I last saw h— alive on July 12 19 21, and that death occurred, on the date stated above, at 5.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward J. Cornelius, M. D.

, 19 (Address) 114 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Cathedral Cemetery	July 21 19 21.

20 UNDERTAKER W. H. Offutt, Jr. ADDRESS 328 S. Payson St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state nation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55462

CERTIFICATE OF DEATH.

D 55462

REGISTERED NO. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 808 S. Eutaw St, ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard D. Nash. (C).

(Residence in Baltimore: No. 622 Warner St.

St.: 42 yrs., 4 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH, February 20th. 1879., 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
42 yrs. 4 mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William Nash. (C)

11-BIRTHPLACE OF FATHER (State or Country), Cambridge, Md.

12-MAIDEN NAME OF MOTHER Ella Jonnson (C)

13-BIRTHPLACE OF MOTHER (State or Country), Cambridge, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Nash. (C) wife.

(Address) 622 Warner St.

15- Filed JUL 19 1921, 191. ROBERT J. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 17th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) 1 yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

July 18 1921. (Address) 1017 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	7/19, 1921
20-UNDERTAKER	ADDRESS
Fine Stationery Co	Penna Ave

Spec. 169-15 30 P. 2-6-20 100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5D 55463

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2503 Oak ST. 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Cook

(a) RESIDENCE. NO. 2503 Oak ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 18, 1921

7 AGE: Years ... Months ... Days ... If LESS than 1 day, 3 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Jessie Cathcart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Joseph Cook 2503 Oak St

15 Filed JUL 19 1921 ROBERT I. FRAZIER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1921, to July 18, 1921, that I last saw h— alive on July 18, 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Any other cause may also exist)

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Garland Ennalls, M. D.

, 19 (Address) 1534 - 5th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	July 20 1921
20 UNDERTAKER	ADDRESS
Samuel Hundley	Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55464

CERTIFICATE OF DEATH.

64 D 55464

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mary Louise Brown 7 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 1306 Ethan St

(Residence in Baltimore: No. 1306 Ethan St St. Life yrs., mos. da.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. 1847 - , 1 (Month) (Day) (Year)

7-AGE. 74 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Balto City.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Brown

13-BIRTHPLACE OF MOTHER (State or Country), Trinidad

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Negus

(Address) 718 Franklin

15- Filed JUL 19 1921 ROBERT I. KRAUTH Registrar.

Burial Permit CITY

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18th, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11th, 1921, to July 18th, 1921, that I saw h[illegible] alive on July 17th, 1921, and that death occurred, on the date stated above, at 7:40 a.m. The CAUSE OF DEATH* was as follows:

Uremia following Arteriosclerosis

(Duration) yrs. 7 mos. da.

CONTRIBUTORY (Secondary) Nephritis

(Duration) 2 yrs. mos. da.

(Signed) A. Fra[illegible] M. D.

7/18, 1921. (Address) 22 Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Road — DATE OF BURIAL. July 20, 1921.

20-UNDERTAKER. Samuel Hunter — ADDRESS. 718 Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55465 | 169 | D 55465

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 201 Lauvel Ave ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roland Andrew Bluford jr.

(Residence in Baltimore: No. 201 Lauvel Ave

St. 1 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): baby

6-DATE OF BIRTH, March 2, 1920
(Month) (Day) (Year)

7-AGE, 1 yrs. 4 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Elkridge Md.

PARENTS.

10-NAME OF FATHER, Roland A Bluford Sr.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Alice Vonkarstedt

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant) Roland A Bluford Sr.

(Address) 201 Lauvel Ave.

15-JUL 19 1921 Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came (o.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Drowning

Accident

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) ....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner.)

7/19/1921 (Address) 3632 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Annapolis Md. DATE OF BURIAL, 7/20, 1921

20-UNDERTAKER Townsend & Son ADDRESS 3617 Roland Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 55466 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D 55466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1405 n Washington Ave (Ward) REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma S. Kreiter

(Residence in Baltimore: No. 1405 n Washington Ave St.; Yrs., Mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Dec. 25, 1869 (Month) (Day) (Year)

7-AGE, 51 yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER, Aug. Schwab

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Caroline Kruckman

13-BIRTHPLACE OF MOTHER (State or Country). Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Weber

(Address) 2121 E. Oliver St.

15- JUL 19 1921 ROBERT J. KREUTER

Filed....., 191. Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 17, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Inglis M. D.
(Coroner)

....., 191... (Address) 4 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto. Cem. DATE OF BURIAL, July 22 1921

20-UNDERTAKER Margaret D. Flynn ADDRESS 722 Light St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D'trembra

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55467

CERTIFICATE OF DEATH.

15 V

D 55467

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 S. Monford Ave ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude D'trembra

(Residence in Baltimore: No. 611 S. Monford Ave St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, July (Month) 17 (Day), 1921 (Year)

7-AGE, ...yrs. ....mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....Infant....
(b) General nature of industry, business, or establishment in which employed (or employer) ....0....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John D'trembra

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lena Knievel

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ....Mabel Belt....

(Address) ....1320 N. Charles St.

15- JUL 19 1921 ROBERT I. KRAUTER

Filed ....., 191... Assistant Asst. Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 1921, to July 18 1921, that I saw her alive on July 17 1921, and that death occurred, on the date stated above, at 5.56 P. m.

The CAUSE OF DEATH* was as follows:

1. Premature birth

.....

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ....Mabel Belt.... M. D.

July 19..., 1921 (Address) 1320 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem.

DATE OF BURIAL, July 19..., 1921.

20-UNDERTAKER M. J. Sadowski.

ADDRESS 705 S. Ann St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. In CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 55468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 V

D 55468

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1804 Gough ST. V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lund

(Residence in Baltimore: No. 1804 Gough st St(yrs. 28 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 10, 1869
(Month) (Day) (Year)

7-AGE, 52 yrs. 2 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Rigger in Balto
(b) General nature of industry, business, or establishment in which employed (or employer)..... City Fire Dept 03 V

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, John Lund

11-BIRTHPLACE OF FATHER (State or Country) England

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amie F Lund

(Address) 1804 Gough st

15- JUL 19 1921 191.. ROBERT J KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Thomas Ryan M. D.
(Coroner)

July 19, 1921 (Address) 810 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Oak Lawn

DATE OF BURIAL, July 20, 1921

20-UNDERTAKER John F Denny

ADDRESS 715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55469

CERTIFICATE OF DEATH.

D 55469

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 S. Sharp ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruby Goburn

(a) RESIDENCE. NO. 712 S. Sharp ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr, 12, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work [illegible]

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Herbert Goburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Florence Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Florence Goburn
(Address) 712 S. Sharp

15 Filed JUL 19 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 15, 1921, to July, 18, 1921, that I last saw h... alive on July, 17, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Otitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no,

What test confirmed diagnosis?

(Signed) Wm Sommerlad M. D.

7/19 1921 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	July 20 1921
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	[illegible] Monty

N. B.—WRITE PLAINLY WITH LEAD PENCIL. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated so that it may be properly classified. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55470

CERTIFICATE OF DEATH.

28 D 55470

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 S. Hare ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A. Fichtler

(a) RESIDENCE. No. 31 S. Hare ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Fichtler

6 DATE OF BIRTH (month, day, and year) Dec. 21/1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30 Years	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can maker do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank Fichtler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Eva Ott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Emma Fichtler (Address) 31 S. Hare st.

15 Filed JUL 19 1921 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1920, to July 17, 1921.

that I last saw h[illegible]ive on July 17, 1921.

and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B

7 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 7 1

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 7

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) B V Kelly, M. D.

, 19 (Address) 100 N Eastwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	20 1/19
20 UNDERTAKER	ADDRESS
J. S. J. Herr	156 N. Luzerne.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 55471 — 1704 D 55471

1-PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 2802 Huntingdon St. 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johannah M. Yagle

(Residence in Baltimore: No. 2802 Huntingdon St.; 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female — 4-COLOR OR RACE: White — 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: April 2, 1861 (Month) (Day) (Year)

7-AGE: 60 yrs. ..... mos. ..... ds. — If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Balto Co

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Pauline Ebbinghaus

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Yagle

(Address) 2802 Huntingdon

15-

Filed JUL 19 1921, 19..

BOBERT I TEUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July 18th (Month) (Day), 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12th, 1921. to July 18th 1921. that I saw h[illegible] alive on July 18th 1921. and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Chronic Diffuse Nephritis,
(Duration) 1 yrs. ..... mos. ..... ds
Contributory (SECONDARY) Pulmonary Edema
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William Garth Thorton M. D.
July 19th, 1921. (Address) 2913 Huntingdon Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: 7/20, 1921

20-UNDERTAKER: William Cook — ADDRESS: 502 E Nath

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55472

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55472

120

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 Annapolis ave St.; 25 WARD)

2-FULL NAME William H Easley

(a) RESIDENCE. NO. 1229 Annapolis ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed Matilda Easley

6 DATE OF BIRTH (month, day, and year) June 7/1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Balto. Md

9 BIRTHPLACE (city or town) (State or country) Thomas H Easley

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Elizth Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Wm M Sullivan 1224 Annapolis Ave

15 Filed JUL 19 1921 MERRY I. HUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from June 24 1921 to July 17 1921.

that I last saw h[e] alive on July 17 1921.

and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo L McKieffer M. D.

July 19 1921 (Address) Mooresville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	July 19 1921
20 UNDERTAKER	ADDRESS
Wm Cook	5326 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1104 D 55473

1-PLACE OF DEATH
CITY OF BALTIMORE (No. John Hopkins Hospital ST. 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Begg Jr

(Residence in Baltimore: No. 1632 E. Fort Ave St.; yrs. 4 mos.) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Nov 3, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. ....ds.
If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country) Washington D.C.

PARENTS.

10-NAME OF FATHER. William Begg

11-BIRTHPLACE OF FATHER (State or Country) Philadelphia

12-MAIDEN NAME OF MOTHER Anna Stevens

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Begg Jr

(Address) 1632 E. Fort Ave.

15-
Filed JUL 19 1921 191.... ROBERT I. KRAUTH
Registrar.
Social Service Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. Shedden M. D.
(Coroner)
7-19-21, 191... (Address) 4 E. Lex. Bal.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Washington D.C.

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill — DATE OF BURIAL. July 19., 1921

20-UNDERTAKER William Cook — ADDRESS 502 E Nath Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 55474

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55474

CERTIFICATE OF DEATH.

71

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 W. Hoffman ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Samuel Nutter

(a) RESIDENCE NO. 420 W. Hoffman ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26-1919

7 AGE — Years: 2 — Months: 1 — Days: 22 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Atlantic City New Jersey

PARENTS

10 NAME OF FATHER: Albert Heinle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Nutter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Nutter

(Address): 420 Hoffman St

15 Filed JUL 19 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1921 to July 18, 1921.

that I last saw him alive on July 18, 1921.

and that death occurred, on the date stated above, at 10:00am

The CAUSE OF DEATH* was as follows:

Convulsions

Constipation and phimosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion, Coma.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. White M. D.

, 19 (Address) 1118 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: July 20 '21

20 UNDERTAKER: Saml K Hunsley

ADDRESS: Mt Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55475

CERTIFICATE OF DEATH.

1301

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Franklin Square Hospital WARD 21)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Elenore Wilburn

(a) RESIDENCE. NO. 748 Ramsey ST., 21st WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	White	Married

5a If married, widowed, or divorced (or) WIFE of John Wilburn

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housedutties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Ben Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Martinsburg W Va

12 MAIDEN NAME OF MOTHER Georgiana Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant (Address) Husband; John Wilburn 748 Ramsey St Baltimore

15 Filed JUL 20 1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17

I HEREBY CERTIFY, That I attended deceased from July 12 1921, to July 19 1921, that I last saw h~~im~~er alive on July 19 1921, and that death occurred, on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH* was as follows:

Operation for Pelvic Abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation for Ileus with Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 18, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clin Findings

(Signed) Howard M Bubert M. D

. 19 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. Frederick Md

DATE OF BURIAL 7-21 1921

20 UNDERTAKER ROBERT BROOKS & SON

ADDRESS Calhoun & Hollins sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 55476

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 520 S. Durham ST.: V WARD)

2-FULL NAME Helen Starzynski

(a) RESIDENCE. NO. 520 S. Durham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 24-1921

7 AGE — Years: — Months: 2 — Days: 25 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Kaz. Starzynski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Helen Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Helen Starzynski
(Address): 520 S. Durham.

15 Filed JUL 20 1921 ROBERT I. FRUTER Registrar
Burial permit ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1921, to July 19, 1921, that I last saw h[illegible] alive on July 15, 1921, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis & Otitis Media

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions & Uremia Fatal

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N. Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) H. N. Bruehl, M. D.

7/19. 1921 (Address) 1625 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: July 20 1921

20 UNDERTAKER: William Fiackowski — ADDRESS: 1618 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION in plain terms, so

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55477.

CERTIFICATE OF DEATH.

104 D 55477

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 S. Bond ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Brulinska

(Residence in Baltimore: No. 830 S. Bond St.; ....yrs., 7 mos. 28 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Nov (Month) 22 (Day), 1920 (Year)

7-AGE, ...yrs. 7 mos. 28 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) .. Child

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Celestyn Brulinska

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Marcyanna Gatowska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celestyn Brulinska

(Address) 830 S Bond

15- Filed JUL 20 1921, 191.. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 19 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11 1921, to July 19 1921, that I saw her alive on July 18 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ....yrs. ....mos. 17 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) John H. Kehberger M. D.

July 19, 1921 (Address) 1709 Aliceanna St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Holy Rosary	July 21, 191..
UNDERTAKER	ADDRESS
[illegible] Trautfarter	16 S Eaton

D 55478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55478

CERTIFICATE OF DEATH.

170

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST. 25 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Hopkins

(Residence in Baltimore: No. Mt. Winans St.; 57 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Glass works

9-BIRTHPLACE, (State or Country), Balto City,

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Asylum Hospital

(Address) Mt Winans

15-

FILED JUL 20 1921 191 [redacted] I KRAVER

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 17, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) aforesaid that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis &
Cardiac Insufficiency

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H. Mitchell M. D. (Coroner.)

July 19 1921 (Address) 700 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS ONLY)

At place of death yrs. mos. 14 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Westport Md

Former or usual residence Westport Md

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn — DATE OF BURIAL, July 20 1921

20-UNDERTAKER John H Trading — ADDRESS 142 Hill St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55479

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50

D 55479

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Wholecoal St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Gaines

(a) RESIDENCE. No. 1312 Wholecoal ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Fontaine A Gaines

6 DATE OF BIRTH (month, day, and year) June 15 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife of Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Richard Shirley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond

12 MAIDEN NAME OF MOTHER Jane Goode

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant (Address) Fontaine A Gaines 1312 Wholecoal

15 FILED JUL 20 1921 ROBERT J. KRAUS, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1921, to July 17, 1921, that I last saw h[illegible] alive on July 16, 1921, and that death occurred, on the date stated above, at 10.55 [illegible] m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Presumably

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) William H. Wright M. D.

(Address) 120 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 21 1921
20 UNDERTAKER James A Davis	ADDRESS 1302 Preston St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55480

CERTIFICATE OF DEATH.

91 ~ D 55480

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2703 Mc Elderry St ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lois Hilan Stephney

(Residence in Baltimore: No. 2703 Mc Elderry St St.; yrs., mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, June 29, 1921.
(Month) (Day) (Year)

7-AGE, ...yrs. 20 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER, Howard Stephney

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Florence Estella Gibson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Stephney

(Address) 2703 Mc Elderry St

15- Filed JUL 20 1921, 191.... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 1921, to July 19 1921, that I saw her alive on July 18 1921, and that death occurred, on the date stated above, at 5.15 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) Albert C. Seuberg M. D.

July 19, 1921. (Address) 2027 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	July 20, 1921
20-UNDERTAKER	ADDRESS
Milton Davis	317 N. Eden St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55481

CERTIFICATE OF DEATH.

1920 D 55481

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Katz

(a) RESIDENCE. NO. 1022 Baltimore St W- ST., WARD. Baltimore
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Forbidden mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	37	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Teacher 068

(c) Name of employer: Not Known

9 BIRTHPLACE (city or town) (State or country): Not Known Russia

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known Russia.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known Russia.

14 Informant: Records of Mt Hope Retreat
(Address): Mt Hope Balto md.

15 Filed JUL 20 1921 ROBERT J. KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd 1909 to July 19 1921, that I last saw her alive on July 15th 1921, and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr Mania -

abt (duration) 10 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

July 19, 1921 (Address) Mt Hope Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	July 20 1921

20 UNDERTAKER: Jack Lewis ADDRESS 1411 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55482 D 55482

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2213

CITY OF BALTIMORE (No. 2213 Whittier Av., ST.: 13 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wolf Klein

(Residence in Baltimore: No. 2213 Whittier Av., St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, ..., 1855
(Month) (Day) (Year)

7-AGE, 66 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... J. Krauss .....

(Address) ..... 1411 E. Balto St.

15-JUL 20 1921 ROBERT J. KRAUTER

Filed....., 191... Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... July ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) ..... find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonar Disease of Heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

July 20 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Dehren Wash Co — DATE OF BURIAL, July 20 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55483

CERTIFICATE OF DEATH.

79 D 55483

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William Applewhaite

(a) RESIDENCE. No. 2937 N. Calvert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs W. Applewhaite

6 DATE OF BIRTH (month, day, and year) Dec 11-1863.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Richard Applewhaite

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Crossley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mary M. Applewhaite
(Address) 2937 N. Calvert St

15 Filed JUL 20 1921 19 ROBERT P. KRUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from June 28th 1921, to July 19th 1921, that I last saw h. alive on July 19th 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Collateral).

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? N. Y.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) T. H. Jamnbaugh M. D.

7/19. 1921 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	July 21 1921

20 UNDERTAKER John O. Mitchell ADDRESS 501 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55484

CERTIFICATE OF DEATH.

170

D 55484

1-PLACE OF DEATH Forest Park · REGISTERED NO.....

CITY OF BALTIMORE: (No. 3109 Granada Ave · ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos G. Newton

(a) RESIDENCE. NO. 3109 Granada av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Newton

6 DATE OF BIRTH (month, day, and year) July 9-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Sampson Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Theresa Nibbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs E. A. Sharretts (Address) 3109 Granada Ave

15 FILED JUL 20 1921 ROBERT F. KLAEBE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1921, to July 19, 1921, that I last saw h im alive on July 19, 1921, and that death occurred, on the date stated above, at 7.30a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis —

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J Walsh, M. D.

July 19 1921 (Address) 212 E St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 21, 1921
20 UNDERTAKER	ADDRESS
John A Mitchell	120 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55485

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55485

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.; 76 WARD) 79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Ward

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Pat Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records.
(Address) New City Hospital.

15 Filed JUL 20 1921 19 [illegible] Registrar

Burial (or Removal) Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1921 to July 19, 1921, that I last saw her alive on July 18, 1921, and that death occurred, on the date stated above, at 6:15 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

7/19/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Maurice Roxbury	July 24 1921
20 UNDERTAKER	ADDRESS
Cathedral Cemetery	230 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—[illegible] P. C. 1000 Blks.

D 55486

D 55486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 Hope ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Edell

(a) RESIDENCE. No. 1818 Hope ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 7/15/1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Born Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Edell

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Nora Donahue

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Joseph Edell
(Address) 1818 - Hope St

15 Filed JUL 20 1921 19... DEATH [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15 1921 to July 19 1921 that I last saw him alive on July 19 1921 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia 4
Hemorrhagic Purpura

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Inflammation of Lung

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. J. Carman, M. D.

7-19-1921 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart New	7/20/1921

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hanford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55487

CERTIFICATE OF DEATH.

8-91

D 55487 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 Albemarl St.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hellen Doris Darago

(a) RESIDENCE. NO. 310 Albemarl ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) 000
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath

PARENTS

10 NAME OF FATHER George Darago

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bath

12 MAIDEN NAME OF MOTHER Lucy Pritchard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bath

14 Informant George Darago
(Address) 310 Albemarl

15 Filed JUL 2 1921 ROBERT E. LAMPE Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1921, to July 19, 1921, that I last saw her alive on July 19, 1921, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 002 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin Sipus Pooley M. D.

July 21, 1921 (Address) 1500 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
H Vincent	July 21 1921

20 UNDERTAKER Wendell Dippel & Son ADDRESS 378 N

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55488

D 55488

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Warfield

(a) RESIDENCE. NO. None ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co., Maryland

PARENTS

10 NAME OF FATHER George Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co., Maryland

12 MAIDEN NAME OF MOTHER Sarah McAllister

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JUL 20 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1921

17

I HEREBY CERTIFY, That I attended deceased from July 13, 1921, to July 18, 1921, that I last saw her alive on July 18, 1921, and that death occurred, on the date stated above, at 10:00 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

7/19/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Sec	July 20 1921
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa ne

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55489

CERTIFICATE OF DEATH.

109

D 55489

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1838 Rutland Av ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L Rice

(a) RESIDENCE. No. 1838 Rutland Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederika Rice

6 DATE OF BIRTH (month, day, and year) Aug 21 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Dry Dock

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md

PARENTS

10 NAME OF FATHER Daniel Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown Md

12 MAIDEN NAME OF MOTHER Emelia Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mercersburg Pa.

14 Informant Clarence Rice
(Address) 1838 Rutland Av

15 Filed JUL 20 1921 ROBERT I. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1919. to July 17 1921.

that I last saw him alive on July 17 1921.

and that death occurred, on the date stated above, at 11.15a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 6. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) 1 yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death? 1838 Rutland Av

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo L Dilyacks, M. D.

, 19 (Address) 2818 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	July 21 1921
20 UNDERTAKER Philip Herring	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55490

D 55490

CERTIFICATE OF DEATH.

REGISTERED NO. 1021

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2619 Fait Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Iszkiewicz

(a) RESIDENCE. NO. 2619 Fait Ave ST.. 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. How long in U. S., if of foreign birth? 14 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-23-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Anthony Iszkiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rosa Dembeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburg Pa

14 Informant Rosa Iszkiewicz
(Address) 2619 Fait Ave

15 JUL 20 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1921, to July 18, 1921.

that I last saw her alive on July 18, 1921.

and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. J. McAvoy, M. D.

July 19/21 (Address) 839 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	July 20 1921

20 UNDERTAKER Stanley Stalkowski ADDRESS 100 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55491 . HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55491

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4917 Augusta ave Ward 27)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Bromwell

(a) RESIDENCE. No. 4917 Augusta Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura V Bromwell

6 DATE OF BIRTH (month, day, and year): March 28/1843

7 AGE — Years: 78 — Months: 3 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George H Bromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Tougeon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Laura V Bromwell 4917 Augusta Ave Lauvale

Filed 7/11 19 21

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1921

17

I HEREBY CERTIFY, That I attended deceased from July 11 . 1921 . to July 18 . 1921 .

that I last saw him alive on July 18 1921 .

and that death occurred, on the date stated above, at 10 45 A M

The CAUSE OF DEATH* was as follows:

Right Hemiplegia
(Cerebral Hemorrhage)

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary): Right Hemiplegia (Cerebral Hemorrhage)

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

7/19 1921 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 21 1921

20 UNDERTAKER: H. M. Cook Sons & Trabert — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55492

CERTIFICATE OF DEATH.

115 D 55492

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George [illegible] Milske

(a) RESIDENCE. No. 337 E 21st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Milske

6 DATE OF BIRTH (month, day, and year) July 21, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman 061

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles Milske

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Wisner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Milske (Address) 337 E 21 Street

15 Filed JUL 20 1921 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 17 . 1921 . to July 19 . 1921 . that I last saw him alive on July 19 . 1921 . and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Cholecystitis - (Obstruction due to adhesions)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 17, 1921

Was there an autopsy?

What lest confirmed diagnosis? Examination Operation

(Signed) Lee L Wisner M. D.

. 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 23 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E Fath. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55493

CERTIFICATE OF DEATH.

151

D 55493

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 S Second ST.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Albert Joseph Mercurio

(Residence in Baltimore: No. 707 S. Second St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 20 (Day) 1921 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 9 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Mercurio

11-BIRTHPLACE OF FATHER (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER Barbara Walls

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Barbara Mercurio .....

(Address) ..... 707 S. Second St. .....

15- ROBERT J KRAUTER

Filed JUL 20 1921 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 20 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19 1921, to July 19 1921, that I saw h/m alive on July 19 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

..... Miscarriage - Immediate Cause .....

.....

..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ....yrs....mos....ds.

(Signed) ..... Geo. J. Goldbeck Jr. M. D.

July 20, 1921. (Address) 806 Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cem. DATE OF BURIAL, July 24 1921

20-UNDERTAKER Lilly and Zeile ADDRESS 403 S Wolfe St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55494

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55494

30

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: Balto WARD)

2-FULL NAME Arthur Emil Lindner

(a) RESIDENCE. No. 3720 Gough St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Paula Lindner

6 DATE OF BIRTH (month, day, and year) Oct 12 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hurle Packing Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Bernhard Lindner

11 BIRTHPLACE OF FATHER (city or town).. (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Schuman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Paula Lindner
(Address) 3720 Gough St

15 Filed JUL 21 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1921, to July 19, 1921, that I last saw h'i, alive on July 19, 1921, and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death? Mercy Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L. Erwin M. D.

. 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Evanglical Cem.	July 21 1921
20 UNDERTAKER	ADDRESS
H. Sandor Sons	1710 Pleasant St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

149461

D 55495

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55495

CERTIFICATE OF DEATH.

+104

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Pakotski

(a) RESIDENCE. No. Colgate P.O. Fallsway St. Road. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	28.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Adam Pakotski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia - Poland

12 MAIDEN NAME OF MOTHER Katie Dom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russian Poland

14 Informant (Address) Mrs. Pezda.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

JUL 20 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1921, to July 19, 1921, that I last saw h... alive on July 19, 1921, and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery)

(duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James C. Fox, Jr, M. D.

7/19/, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	July 21 1921
20 UNDERTAKER	ADDRESS
H. Lander & Son	1702 Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55496

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55496

CERTIFICATE OF DEATH.

52

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 W. Preston ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Parks

(a) RESIDENCE. No. 315 W - Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Parks

6 DATE OF BIRTH (month, day, and year) Apr 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Charles Co Md

PARENTS

10 NAME OF FATHER James Short

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chas Co Md

12 MAIDEN NAME OF MOTHER Bettie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chas Co Md

14 Informant Jennie Brown (Address) 3520 Brehm

15 Filed Robert P Harrison, Registrar

Burial Permit Clerk.

OL 2 01921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 17 . 1921 . to July 19 . 1921 . that I last saw her alive on July 18 . 1921 . and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Malasma Suprarenalis

(duration) yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) Coma Convulsions

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gustav Goldmann, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL July 22nd 1921

20 UNDERTAKER Harris & Ladrigh — ADDRESS 364 W Cary

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Emma Simms)

D 55497. HEALTH DEPARTMENT—CITY OF BALTIMORE D 55497

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 W Chase ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Simms

(Residence in Baltimore: No. 22 W. Chase St. 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH. 1896
(Month) (Day) (Year)

7-AGE. 24 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Employment
(b) General nature of industry, business, or establishment in which employed (or employer): agency g.D.86

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. John Wilkinson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Clara Reed

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Dockens

(Address) 22 W. Chase St.

15-

JUL 20 1921 Robert P. Harrison, ..., 191.....
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: July 18th, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18th 1921, to July 18th 1921, that I saw h.. alive on July 18th 1921 and that death occurred, on the date stated above at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) ..... yrs. ..... mos. 12 hrs. ds.

CONTRIBUTORY (Secondary) Pneumonia (Duration) ..... yrs. ..... mos. 12 hrs.

(Signed) A. Jan Ellis M. D.

7/18, 191.. (Address) 924 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL, 7/21/21, 191...

20-UNDERTAKER Felix B. Fyan

ADDRESS 102 E Mulberry St

WHITE PEARL, WITH UNFADING INK—THIS IS A PERMANENT RECORD

21—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55498 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55498

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarit Wilkerson

(a) RESIDENCE. NO. 416 N. Green ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jarretta
(State or country) Virginia

PARENTS

10 NAME OF FATHER Leo F. Wilkerson

11 BIRTHPLACE OF FATHER (city or town) San Antonio
(State or country) Texas

12 MAIDEN NAME OF MOTHER Ida Menelly

13 BIRTHPLACE OF MOTHER (city or town) Gonzales
(State or country) Texas

14 Informant Leo F Wilkerson
(Address) 416 N Green St.

15 Filed JUL 20 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1921, to July 19, 1921, that I last saw h alive on July 19, 1921, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Hem Colitis

(duration) yrs. mos. 03 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 416 N. Green St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs + symptoms

(Signed) W B Jones, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL July 28 1921

20 UNDERTAKER William Cook — ADDRESS 502 E 16th

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of date is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55499

CERTIFICATE OF DEATH.

REGISTERED NO. 14 77

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Harris

(a) RESIDENCE. No. 1801 Divison St. ST., WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Andrew Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Addie Rash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed 19 Robert P Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 23, 19 21, to July 18, 19 21, that I last saw h... alive on July 17, 19 21, and that death occurred, on the date stated above, at 1:30 A. m.

THE CAUSE OF DEATH* was as follows:

Acute fibrinous pericarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

7/18/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 18 1921
20 UNDERTAKER	ADDRESS
George T. Gilbert	513 Fairmount Ave

JUL 20 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55500 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55500

61

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 Fleet ST.: 2nd. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wladislaw Leon Nawrocki,

(a) RESIDENCE. NO. 1821 Fleet ST., 2nd. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 14 - 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child, do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.,

PARENTS

10 NAME OF FATHER Frank Nawrocki,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland,

12 MAIDEN NAME OF MOTHER Vincintina A. Smrerdzrnsky,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Mrs. V.A. Nawrocka,
(Address) 1821 Fleet Street

15 Filed JUL 20 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1921

17 I HEREBY CERTIFY, That I attended deceased from July. 8 '21, to July 20, 1921, that I last saw h[illegible] alive on July 20, 1921, and that death occurred, on the date stated above, at 10. a- m.

The CAUSE OF DEATH* was as follows:

Meningitis. cerr

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Rosen M. D.

July 20-21 (Address) 801 N Decatur

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	July 21 1921
20 UNDERTAKER M. F. Sadowski	ADDRESS 1058 E. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Simple

D 55501 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 D 55501

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2860 Harlem St.: 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. E. Ross

(Residence in Baltimore: No. 2860 Harlem Ave. St.; yrs., 5 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, ... November (Month) ..., 1848 (Year) (Day)

7-AGE, ... 73 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 050

9-BIRTHPLACE, (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Dissinger

(Address) 3025 Auchentoroly St.

15-

Filed ....., 191.....

Registrar.

Robert P. Harrison,

JUL 20 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) ..... Jury ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Cellulitis of Leg

..... 3 mos.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... J. J. Hennessy ..... M. D.
(Coroner)

July 20 1921 (Address) 2 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Greenmount Cem. DATE OF BURIAL July 21. 1921

20-UNDERTAKER David Easton ADDRESS 916 6a ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

died at Mercy Hospital

D 55502

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55502

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md University Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lt. Elizabeth X De Shazo

(a) RESIDENCE. No. 29 W. Biddle ST., WARD. Alabama.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred X yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: No

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Lt De Shazo

6 DATE OF BIRTH (month, day, and year): August 16th 1895

7 AGE: Years 25 Months 11 Days 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): U.S.

(c) Name of employer: Milton Co Mass

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Richard Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Lt De Shazo 400 Warwick Road Hilton Village Va

15 Filed JUL 21 1921 19 ROBERT J. KRAUSER Registrar

Burial permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/20/21 19

17 I HEREBY CERTIFY, That I attended deceased from 7-17-21, 19..., to 7-20-21, 19

that I last saw h[illegible] alive on 7-20, 1921

and (that death occurred, on the date stated above, at 7.40 A m

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

19 (Address) 6 West Fort St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Birmingham Ala	July 21st 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Main St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55503

CERTIFICATE OF DEATH.

120 D 55503

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3309 Fairview Ave. St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Babette Wohl

(a) RESIDENCE. No. 3309 Fairview Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Max Wohl

6 DATE OF BIRTH (month, day, and year) April 1, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Relzheim, Germany

PARENTS

10 NAME OF FATHER -------- Feibleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Babette Fellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Arthur I. Kline

(Address) 3309 Fairview Ave

15 Filed JUL 21 1921 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17

I HEREBY CERTIFY, That I attended deceased from June 28, 1921, to July 19, 1921, that I last saw her alive on July 19, 1921, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) Don't Know ms. ds.

CONTRIBUTORY (Secondary) Bright's Disease

(duration) Don't Know ms. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatic

(Signed) Henry Kemp M. D.

, 19 (Address) 2507 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	7/21/21 19

20 UNDERTAKER Henry W. Mears & son ADDRESS 2025 N. Calvert St.

Spec.—8-24-14—M. & T.—2000 Bks.

(Dangerfield

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55504

CERTIFICATE OF DEATH.

28 D 55504

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 514 Park ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas A Dongerfield

(Residence in Baltimore: No. 514 Park St.; ... yrs., 5 mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Color

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 ..... (Year)

7-AGE, 43 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Painting Firm

9-BIRTHPLACE, (State or Country), Die in Balt- 5 yrs Washington D.C.

PARENTS.

10-NAME OF FATHER, Wilfred Dongerfield

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Augustus A Dongerfield

(Address) 514 Park St

15-

Filed JUL 21 1921 191 ..... ROBERT J. KRAUTER Registrar.

JUL 21 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14th 1921, to July 19th 1921, that I saw h[illegible] alive on July 14th 1921, and that death occurred, on the date stated above, at 1230 P.M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Nil

(Duration) ... yrs. ... mos. ... ds.

(Signed) A. Lee Ellis M. D.

7/20, 1921 (Address) 724 Mad[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Harmony Cem Washington

DATE OF BURIAL, July 21 1921

20-UNDERTAKER Wm R A Elliott

ADDRESS 1735 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Remarks Probably Tuberculosis

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

D 55505

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 55505

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 50 S Pamphlet St. 3 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Jane Foot.

(Residence in Baltimore: No. 50 S Pamphlet St.; yrs., 13 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ... (Month) — (Day) — , 1 (Year)

7-AGE: 37 yrs. 7 mos. 12 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): House work

9-BIRTHPLACE (State or Country): Cockeysville Md
Lie in Balt-Md 13-years

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Allen

(Address) 3-36 East 21-

15- JUL 21 1921 191.. ROBERT J KRAUTER

Bur'l (Cr.) Reg'd

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Coroner, (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Edema, Intracerebral

Hemorrhage 3 mos. to 1 2 mos.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

July 20 1921 (Address) 1657 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Laurel Cem

DATE OF BURIAL, July 22, 1921

20-UNDERTAKER: Mrs Robert A Elliott

ADDRESS 1725- Eastland Av

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55506

CERTIFICATE OF DEATH.

91 ✓ D 55506

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Alice Rascovar

(Residence in Baltimore: No. 2127 Bolton St. Balto ST. Fifth yrs.... mos.... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Sept. (Month) ..... (Day), 1887 (Year)

7-AGE, 33 yrs. 10 mos. ? da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife 07
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Louis S. Fernheimer.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Fannie D. Herford.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel L. Fernheimer

(Address) 2109 Bolton St.

15. Filed JUL 21 1921, 191..... ROBERT I. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15, 1921, to July 19, 1921, that I saw h[illegible] alive on July 19, 1921, and that death occurred, on the date stated above, at 9.33 P. M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ..... yrs. ..... mos. 3 da.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. 4 da.

(Signed) Frank Deborthenston M. D.

July 19, 1921. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 5 da. In the State 33 yrs. 10 mos. ? da.

Where was disease contracted, if not at place of death?.....

Former or usual residence 2127 Bolton St. Balto.

19-PLACE OF BURIAL OR REMOVAL, Harsinia Cemetery — DATE OF BURIAL, July 21, 1921

20-UNDERTAKER J. Ahrens & Co — ADDRESS 1611 Madison

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55507

CERTIFICATE OF DEATH.

34

D 55507

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 Bolt ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph F. Goode

(a) RESIDENCE. NO. 1831 Bolt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Granville H. Goode.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlottesville Va.

12 MAIDEN NAME OF MOTHER Margaret E. Mellon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Granville H. Goode
(Address) 1831 Bolt Street

15 Filed JUL 21 1921 19 ROBERT J. KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19 1921, to July 19 1921, that I last saw him alive on July 19 1921, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) P. B. Colitis Myelitis Pneumonia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Brunelle M. D.

7/22 19 21 (Address) 1279 Hillman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	July 22 1921

20 UNDERTAKER John J. Cowan Son

ADDRESS 908 Hollins St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55508

CERTIFICATE OF DEATH.

79 D 55508

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 369 W. Preston St., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Denby

(Residence in Baltimore: No. 369 W. Preston St.; 63 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. ....., 1858
(Month) (Day) (Year)

7-AGE. 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE. (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER. John Denby

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Riding

13-BIRTHPLACE OF MOTHER (State or Country). Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Gregory

(Address) 369 W. Preston

15- Filed JUL 21 1921, 191... ROBERT J. KRAUTER Registrar

Burial Form No. 1

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 16th 1921, to July 20th 1921, that I saw h[illegible] alive on July 19 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Mitral insufficiency)

..... (Duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None Known

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. J. Kidd M. D.

July 20, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cemetery

DATE OF BURIAL. July 22, 1921.

20-UNDERTAKER Chas. J. Bailey

ADDRESS 1479 Jefferson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55509

REGISTERED NO. 1046 D 55509

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 Cambrige ST.: I- WARD)

2-FULL NAME PRAKSZIDA F. SLOWIKOWSKA,

(a) RESIDENCE. NO. 2004 Cambrige ST., I- WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. I5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6-I92I.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	4	I5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant, D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.,

PARENTS

10 NAME OF FATHER John Slowikowski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Antonina Rynecka,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant John Slowikowski, (Father)

(Address) 2004 Cambrige Street

15 Filed JUL 21 1921 EDWIN J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2I- 1921.

17 I HEREBY CERTIFY, That I attended deceased from July 19 1921, to July 21 1921,

that I last saw h[illegible] alive on July 21 1921,

and that death occurred, on the date stated above, at 2.30 A- m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) ds. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac Pyrexia 1

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Sowers M. D.

July 21 1921 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Bsm.

DATE OF BURIAL July 21 1921

20 UNDERTAKER M. J. Sadowski.

ADDRESS 705 S. Ann St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 55510

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55510

CERTIFICATE OF DEATH.

X 169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pier 1 Pratt St. ST.; 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Asie Miller

(Residence in Baltimore: No. St.; yrs., mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 39 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seaman
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Hopewell Md.

PARENTS.

10-NAME OF FATHER, Robt Miles

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER E. Holland

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt Miles Jr

(Address) Hopewell

15- Filed JUL 21 1921, 191.... ROBERT I. KRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 16, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) and that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Accidental)
Drowned
Fell from gang board
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

July 21, 191.. (Address) 1027 Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL, ..., 1921
20-UNDERTAKER Commissioner Health.	ADDRESS

Wm. F. WOODALL

UNIVERSITY OF MARYLAND

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55511

D 55511

CERTIFICATE OF DEATH.

1452

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Adams

(a) RESIDENCE. NO. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	B	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Columbus Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sadie Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant
(Address) 70 Lamb St. Balto

15 Filed JUL 21 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1921

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1921, to July 9, 1921, that I last saw h[illegible] alive on July 9, 1921, and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Impetigo - Contagiosa

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pyemia (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Guy N. Linnell, M. D.

7-9-1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUL 21

20 UNDERTAKER

ADDRESS JUL

Burial Permit Issued

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

145

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55512

D 55512

CERTIFICATE OF DEATH.

REGISTERED NO. C 107

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1141 E Bond, ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Robb.

(Residence in Baltimore: No. 1141 E Bond. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, December 24, 1920, 1 (Month) (Day) (Year)

7-AGE, 7 months 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm Robb.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Carrie Lee

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Robb

(Address) 114 E Bond st

15- JUL 21 1921 ROBERT J KRAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquisition (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) G. C. Stadler M. D.
(Coroner.)

July 21 1921 (Address) 143 N Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, July 22 1921

20-UNDERTAKER Theodore Thos ADDRESS 119 Mt St

Bitner

D 55513

HEALTH DEPARTMENT—CITY OF BALTIMORE

91

D 55513

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 423 W. 26 St.; 13 Ward)

REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Bitner

(Residence in Baltimore: No. 423 W. 26 St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W.	

6-DATE OF BIRTH, Dec 24, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0 0

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, James Bitner

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Bertha Stalk

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Bitner

(Address) 423 W 26 St

15- JUL 21 1921 ROBERT J KRAUTER
Filed....., 191.... Clerk
Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Thornton M. D.
(Coroner)

July 20 1921 (Address) 2632 Rd Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Mary's Hampden	July 22 1921
20-UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55514

D 55514

CERTIFICATE OF DEATH.

REGISTERED NO. 1479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Blyler

(a) RESIDENCE. NO. 1524 N. Madeira ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Blyler

6 DATE OF BIRTH (month, day, and year) Mar. 18, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman 073

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Samuel E. Blyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mary J. Lebo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. E. Blyler (Address) 524 Madeira St.

15 Filed JUL 21 1921, 19 Robert P. Harris Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1921, to July 20, 1921, that I last saw him alive on July 20, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cellulitis of face.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Downey, M. D.

, 19 (Address) 623 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisburg Pa.	July 22 1921

20 UNDERTAKER ADDRESS

E. J. Fanning & Son 1460 Battery Ave

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55515

CERTIFICATE OF DEATH.

104 D 55515

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 West ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Edward McNicholas

(Residence in Baltimore: No. 1309 West St.; yrs., 10 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)

6-DATE OF BIRTH, Sept. 1, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Francis McNicholas

11-BIRTHPLACE OF FATHER (State or Country), Texas Md

12-MAIDEN NAME OF MOTHER, Catherine Stewart

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Mc Nicholas

(Address) 1309 West St

15- Filed JUL 21 1921

Robert P. Harrison,
....., 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1921. to July 19 1921.
that I saw him alive on July 19 1921.
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH was as follows:

Gastro-Enteritis

.....
.....
.....

(Duration)....yrs....mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration)....yrs....mos. 2 ds.

(Signed) Benj. D. Hardinge M. D.

July 21, 1921. (Address) 216 N. Carey St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park

DATE OF BURIAL, July 21, 1921

20-UNDERTAKER William Cook

ADDRESS 512 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55516

D 55516

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1062 W Mount St. 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Long

(Residence in Baltimore: No. 1062 W Mount St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Col	Single

6-DATE OF BIRTH. Unknown ....., 1881
(Month) (Day) (Year)

7-AGE. 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country), N. Carolina

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Beach

(Address) 1042 W Mount St

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.

JUL 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1921, to July 19 1921, that I saw h[illegible] alive on July 15 1921, and that death occurred, on the date stated above, at 11,45 [illegible] m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

..... (Duration) ..... yrs. 1 mos. 15 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Coleman M. D.

July 20, 1921 (Address) 1129 W Mt Carmel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Ft Dorchester DATE OF BURIAL, July 22 1921

20-UNDERTAKER Sam'l F. Chase Son ADDRESS 1400 Madison

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks Probably Intercurrent

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide: Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55517

D 55517

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1932 Light ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wesley T. Weeks

(Residence in Baltimore: No. 1932 Light st. St.: .....yrs.. .....mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	white	single

6-DATE OF BIRTH, ... July (Month) 3 (Day), 1921 (Year)

7-AGE,	If LESS than 1 day,
.....yrs. .....mos. 18 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Polly C. Weeks

11-BIRTHPLACE OF FATHER (State or Country), Long Island

12-MAIDEN NAME OF MOTHER Jennie Combs

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Weeks

(Address) 1932 Light.

15-

Robert P. Harrison,

Filed....., 191.....

Registrar.

Burial Permit Clerk.

JUL 21 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 3 1921, to July 20 1921, that I saw h.. alive on July 20 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(Duration) .....yrs. .....mos. 10 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) .....yrs. .....mos. 2 ds.

(Signed) H. R. Campbell M. D.

July 21, 1921 (Address) 164 W. Hamburg St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cem	7/23, 1921

20-UNDERTAKER	ADDRESS
J. Fw McCully	130 E. Fort

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

...OR FOR BINDING

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55518

D 55518

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hosp ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sellman

(a) RESIDENCE. No. 3233 E Baltimore St WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Livingston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Theresa Sellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hosp Baltimore Md

15 Filed Robert P. Harrison, Registrar

JL 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18 1921 to July 20, 1921, that I last saw her alive on July 20, 1921, and that death occurred, on the date stated above, at 5-35 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

12

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacret Heart	July 22 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2046 Eutaw

---

should be stated EXACTLY. PHYSICIAN'S ... state
it may be properly classified. Exact statement of OCCUPA-
on back of certificates.
mation should be carefully supplied. AGE ...
CAUSE OF DEATH in plain terms, so that ...
TION is very important. See instructions on ...

Spmc—6-9-19—H. P. Co.—1000 Bks.

D 55519

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55519

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Love

3 (a) RESIDENCE. NO. 5th ave. and 14th st. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904 Mar 8th

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory operator

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

086

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Wm. S. Love

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Mollie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JUL 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1921, to July 21, 1921, that I last saw her alive on July 20, 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Clyde McNeill M. D.

7-21-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	July 23 1921
20 UNDERTAKER Philip Henrig	ADDRESS 2016 Aliceanna

B—WRITE PLAINLY, WITH INK. ALL items should be properly classified. DATE OF BIRTH and AGE should be carefully supplied. AGE should be stated in years, months and days, so that it may be properly classified. Exact information should be carefully supplied. AGE should be carefully supplied. AGE should be stated in years, months and days, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information should be carefully supplied. AGE should be stated in years, months and days, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55520

D 55520

110

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Bowman

(a) RESIDENCE. NO. 232 N. Ann St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawrence Bowman

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER T. Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed 1921 Robert P. Harrison, Registrar

JUL 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1921, to July 19, 1921, that I last saw her alive on July 19, 31, and that death occurred, on the date stated above, at 11:00 A. m.

The CAUSE OF DEATH* was as follows:

Ischio-Rectal Abscess
Septicaemia
(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pelvic Peritonitis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.

7-19-21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
~~Shady Side, Md.~~ Asbury Dem	July 22 1921
20 UNDERTAKER	ADDRESS
Milton Dant	317 N Eden St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated in years, months and days. Exact information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55521

REGISTERED NO. 1298

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 157 W. Cross ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David E. Sprowl

(a) RESIDENCE. NO. 157 W. Cross ST., 22 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer): Ret

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER James Sprowl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Del

12 MAIDEN NAME OF MOTHER Margaret Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Margaret Bolden (Address) 157 W. Cross

15 Filed JUL 22 1921 19 ROBERT J. CLUTER Registrar

Burial ... Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to July 20, 1921, that I last saw him alive on July 20, 1921, and that death occurred, on the date stated above, at 12-N. m.

The CAUSE OF DEATH* was as follows:

Trauma

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

unknown (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) E E Benston, M. D

7/22/1921 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Elm — DATE OF BURIAL: July 22 192

20 UNDERTAKER: J. W. & E. Evans & Son — ADDRESS: 1428 & Charles Av

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55522

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55522

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2715 St Paul St ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Sewell Thomas

(a) RESIDENCE. NO. 2715 St Paul ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? 72 yrs. 1 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H Thomas

6 DATE OF BIRTH (month, day, and year) May-23-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James P Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Elizabeth McGee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs H. F. Register (daughter)
(Address) 2715 St Paul St

15 Filed JUL 22 1921, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from January 15th 1921, to July 20th 1921.

that I last saw him alive on July 21st 12 M. 1921.

and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Central Hemorrage with left Hemiplegia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardio Nephritis Complicated with Uremia (duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? The Clinical Symptoms

(Signed) Wilmer Brinton, M. D.

, 19 (Address) 1 Cor Eutaw & Preston Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL July 24 1921

20 UNDERTAKER STEWART & MOWER SOUTH

ADDRESS 108 W. NORTH AVE.

BOARD OF HEALTH
Burial Permit Office

N. B.—WRITE PLAINLY. WITH... mation should be carefully supplied. AGE should be properly classified. Early CAUSE OF DEATH in plain terms, so that it may be of certificates. TION is very important. See instructions on back of ce...

D 55523

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 55523

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1215 E. Madison ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Friedman

(a) RESIDENCE. No. 1215 E. Madison ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Friedman

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Herman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20 . 1921 . to July 21 . 1921 . that I last saw him alive on July 21 . 1921 . and that death occurred, on the date stated above, at 12.35 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 24 hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein M. D.

7/21 . 1921 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

CREMATION OR REMOVAL | DATE OF BURIAL 7/23 21

TE PLAINLY, WITH UNFADING INK. Exact statements
on should be carefully supplied. AGE should be
ISE OF DEATH in plain terms, so that it may be properly classified.
N is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55524

CERTIFICATE OF DEATH.

15 D 55524

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1426 N. Eden ST.; 9 WARD)

2-FULL NAME Robert Gorman Christopher

(a) RESIDENCE. NO. 1426 N. Eden ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 21. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 3 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Benjamin F. Christopher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Anna Ethel Norwood

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Anna Ethel Christopher (Address) 1426 N. Eden

15 Filed JUL 22 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1921

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1921, to July 21, 1921, that I last saw him alive on July 21, 1921, and that death occurred, on the date stated above, at 12 00 P m.

The CAUSE OF DEATH* was as follows:

Failure of Respiration
Instrumental Delivery

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward Lewis M. D.

(Address) 4132 Washington Ave 7/22/1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	July 22 1921
20 UNDERTAKER	ADDRESS
George J. Schilling & Sons	1126 E Monument St

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements on back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55525

109395

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104-091

D 55525

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hosp. (Ward) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Johnson

(a) RESIDENCE. No. 644 Pitcher St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27-1920

7 AGE Years 11 Months 23 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hilda Daniel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address) J Hosp

15 Filed JUL 22 1921 19 ROBERT J. KRAUTER Registrar

Burial room Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1921

17 I HEREBY CERTIFY, That I attended deceased from July 9 1921 to July 20 1921 that I last saw h alive on July 20 1921 and that death occurred, on the date stated above, at 3 00 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery).

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Horton Caspare, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem.

DATE OF BURIAL July 23 1921

20 UNDERTAKER Samuel H. Huseby

ADDRESS 518

N. B.—WRITE PLAINLY, and all information required should be carefully supplied. Any omission or mistake may be properly chastised by withholding the certificate. Attention is called to the fact that it may be a misdemeanor to make a false statement in the CAUSE OF DEATH in plain terms, so that it may be understood by the undertaker. See instructions on back of certificate. ATTENTION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 55526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55526

CERTIFICATE OF DEATH.

64-09

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 N. Parrish ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Henry.

(a) RESIDENCE NO. 403 N. Parrish ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - 040

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md Bleard Co. Va

PARENTS

10 NAME OF FATHER Thomas Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Martha Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Virginia Barbour

(Address) 403 Parrish St.

15 Filed JUL 22 1921 ROBERT I. TRAUTEN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 - 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1921, to July 20, 1921, that I last saw him alive on July 19, 1921, and that death occurred, on the date stated above, at 6.05 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Bronchio Pneumonia (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. W. Kennard M. D.

7-24, 1921 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL July 23 1921

20 UNDERTAKER Samuel F. Hinkley ADDRESS 1116 Bolton

N. B.—WRITE PLAINLY, WITH UNFAILING ACCURACY. AGE should be properly classified. Exact statements of certificates. mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55527

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 E. Biddle. St. ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary. C. Matter

(a) RESIDENCE. No. 904 E. Biddle. ST.. 10 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs 11 mos. 24 ds. How long in U. S., if of foreign birth? Life yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a If married, widowed, or divorced (or) WIFE of William. F. Matter

6 DATE OF BIRTH (month, day, and year) July. 27. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph. F. Degenhardt

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary. M. Eisenhardt

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs. William. F. Matter
(Address) 904 E Biddle St

15 Filed JUL 22 1921 . 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July. 21. 1921

17 I HEREBY CERTIFY, That I attended deceased from June 29. 1921. to July 21. 1921.

that I last saw h[illegible] alive on July 21. 1921.

and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) yrs. ? mos. da.

CONTRIBUTORY (Secondary) myocarditis

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

7/22. 1921 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 25 1921

20 UNDERTAKER Henry Hoeck Son

ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY. Matter in every question should be carefully supplied. AGE should be properly classified. Exact information should be carefully supplied. AGE should be given in years, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information should be carefully supplied. AGE should be given in years

Spec. - 6-9-19 - H. P. Co. - 1000 Bks.

D 55528 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55528

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802. N. Bond ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmira Shearman.

(a) RESIDENCE. No. 1802. N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of of Late W. Shearman.

6 DATE OF BIRTH (month, day, and year) May. 4th 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87. Years	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Hannif

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt Md.

PARENTS

10 NAME OF FATHER Watson V. Horn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER E. VanHorn.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Mrs. Ida. Francis
(Address) 1802. N. Bond St.

15 Filed JUL 22 1921 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1921, to July 21, 1921,

that I last saw her alive on July 14, 1921,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation. Hemorrhagic Purpura & Intermittent Pneumonia

(duration) Over 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation & Intermittent Pneumonia

(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. F. Carman, M. D.

7 22 1921 (Address) 1702 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Landon Park Cemetery.

DATE OF BURIAL 7 22 1921

20 UNDERTAKER George L. Ruth.

ADDRESS 1735 Hartford Ave

mation should be entered ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55529

50

D 55529

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 S. Port ST., 1 WARD)

2-FULL NAME Wilhelmina Yost

(a) RESIDENCE NO. 324 S. Port ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 65 yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Yost

6 DATE OF BIRTH (month, day, and year) Jan. 15. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Henry Krenes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) H. Sander Sons 1700 Pred St

15 Filed JUL 22 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 27, 1921, to July 20, 1921, that I last saw her alive on July 20, 1921, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Valvular Disease Heart

(duration) ..... yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fehlings

(Signed) Caleb V. Bothers, M. D.

July 21, 1921 (Address) 1008 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL July 23 1921

20 UNDERTAKER H. Sander Sons ADDRESS 1700 Pred St

N. B.—WRITE PLAINLY. WORDS should be carefully supplied. AGE should be properly classified. Each question must be answered, so that it may be properly classified. Information should be carefully supplied, so that it may be plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. CAUSE. OF DEATH is very important. See instructions on back TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55530

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55530

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 850 S. Bond ST.; 3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexandra Bernaski (If under 1 year, St.; yrs. 3 mos. 11 ds.)

(Residence in Baltimore: No. 850 S. Bond St.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, April (Month) 11 (Day), 1921 (Year)

7-AGE, yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Aleksander Bernacki

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Anna Karla

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Aleksander Bernacki
(Address) 850 S. Bond St.

15-
Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 22 1921, to July 22 1921, that I saw h[er] alive on July 22 1921, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Entero-colitis

(Duration) .....yrs. .....mos. 7 ....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) John H. Kehberger M. D.

July 22, 1921. (Address) 1709 Aliceanna St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus — DATE OF BURIAL, July 23..., 1921

20-UNDERTAKER John M. Walker — ADDRESS 1803 Bank

N.B.—Every item of information should be given so that it may be properly examined. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55531

CERTIFICATE OF DEATH.

79 ✓ D 55531

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 N Charles ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME N Lee Goldsborough

(a) RESIDENCE. NO. 1003 N Charles ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret W. Goldsborough

6 DATE OF BIRTH (month, day, and year) May 23 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2 mo.	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore - Md.

PARENTS

10 NAME OF FATHER Richard Goldsborough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester County. Md.

12 MAIDEN NAME OF MOTHER Jane Edelen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles County - Md.

14 Informant Mrs. Wm. P. Bailey
(Address) Mill Valley Calif

15 Filed JUL 22 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23d 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st 1921, to July 23d 1921.

that I last saw him alive on July 22nd 1921.

and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Val Dis of Lungs Contrib. Cause 3 days

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Tb Intestines Stomach (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? a

(Signed) E L Goldsborough M. D.

19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	7-23 1921
20 UNDERTAKER Emerson Jenkins Howe Co	ADDRESS McCulloh Orchard

N. B.—WRITE PLAINLY. All information should be carefully supplied. Any information may be properly CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

D 55532

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

120

D 55532

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3025 Walbrook Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rev. James Mc Laren

(Residence in Baltimore: No. 3025 Walbrook ave St.; 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH: March (Month) 13 (Day) 1898 (Year)

7-AGE: 73 yrs. 4 mos. 8 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Minister of the Gospel
(b) General nature of industry, business, or establishment in which employed (or employer): M. E. Church

9-BIRTHPLACE (State or country): England

PARENTS

10-NAME OF FATHER: John Mc Laren

11-BIRTHPLACE OF FATHER (State or country): Scotland

12-MAIDEN NAME OF MOTHER: Matilda Wantling

13-BIRTHPLACE OF MOTHER (State or country): England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cora Mc Laren

(Address) 3025 Walbrook ave

15- Robert F. Harrison,

JUL 22 1921, 191 Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14, 1921, to, July 21 1921, that I saw him alive on July 21 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Chronic interstitial nephritis

(Duration) 12+ yrs. mos. ds.

Contributory (SECONDARY): Myocarditis

(Duration) 2+ yrs. mos. ds.

(Signed) Henry T. Collenberg M. D.

July 22, 1921 [Address] 904 N. Charles St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Washington D.C. DATE OF BURIAL: July 25 1921

20-UNDERTAKER: George J. Smith ADDRESS: 1000 N. Fayette St

WHITE PERMIT

Every item of information should be carefully supplied. It may be properly classified. If state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 55533

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 55533

CERTIFICATE OF DEATH.

x 45

1-PLACE OF DEATH Ft.McHenry, Baltimore, Md.

CITY OF BALTIMORE: (No. U.S.P.H.S Hosp.#56 ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bradie Z. McCormick,

U.S.Public Health Service Hosp.#56, Baltimore, Md.

(a) RESIDENCE NO. ST., WARD 36

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
32	--	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glass worker 486

(b) General nature of industry, business, or establishment in which employed (or employer): --

(c) Name of employer: --

9 BIRTHPLACE (city or town) (State or country): West Virginia

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Edgar T. Rosenbrock, Registrar

(Address) USPHS Hosp.#56 Baltimore, Md

15 Filed JUL 22 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 12, 1921, 19..... to July 21, 19 21.

that I last saw him alive on July 21, 19 21.

and that death occurred, on the date stated above, at 9:40 pm.

The CAUSE OF DEATH* was as follows:

Tumor, mixed malignant right neck, abdomen and lungs

--- 2 yrs (duration) -- yrs. -- mos -- ds.

CONTRIBUTORY (Secondary) --

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? -- Date of --

Was there an autopsy? -- Yes

What test confirmed diagnosis? Clinical report

(Signed) Thomas R Payne M. D.

7/22, 1921 (Address) Senior Surgeon (R) USPHS Hosp.#56 Balto.Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charleston W. Va

DATE OF BURIAL: July 24, 19 24

20 UNDERTAKER: Sol Linton

ADDRESS 1127 E Bullitt St

N. B.—WRITE PLAINLY. All information should be carefully supplied. Any CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55534

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 55534

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 925 Eastern ave ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Serpico

(a) RESIDENCE. NO. 925 Eastern ave ST., 3 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Michael Serpico.

6 DATE OF BIRTH (month, day, and year) Jan 22 nd 1861

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
60	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home 100

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Joseph Bossye.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Minnie Goodyear

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant (Address) Joseph Serpico 925 Eastern ave.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

JUL 22 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 - 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 1921 to July 20 1921

that I last saw h alive on July 20 1921 at 5.30 p m.

and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis 0000

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1924 (Address) 422 Fairfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery

DATE OF BURIAL July 23 1921

20 UNDERTAKER Lilly - Zeiler

ADDRESS 403 S Wolfe St

B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be properly classified. Information should be carefully supplied, so that it may be in plain terms, so that it may be properly classified. Information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55535 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55535

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3004 E. Fayette ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bartholomue Lieberth

(a) RESIDENCE. No. 3004 E. Fayette ST., 6 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of the late Margaret Lieberth (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper 086

(b) General nature of industry, business, or establishment in which employed (or employer) Kimball-Tyler

(c) Name of employer Cooperage Co. Balto. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Anna Bayer

(Address) 3004 E. Fayette St.

15 Filed JUL 22 1921, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1921, to July 21, 1921

that I last saw h— alive on July 21, 1921

and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) B. Kelly, M. D.

19 (Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: July 25 1921

20 UNDERTAKER: Lilly - Geier

ADDRESS: 400 S. Wolfe St.

S.—WRITE PLAINLY. All items must be carefully supplied. AGE should be properly classified. Information should be carefully supplied. AGE should be properly classified. Information should be carefully supplied. AGE should be properly classified. Information should

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55536 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55536

CERTIFICATE OF DEATH.

REGISTERED NO. 1426

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rebhan

(a) RESIDENCE. NO. 3xtl Philadelphia ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Rebhan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed Robert P. Harrison, Registrar
JUL 22 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 20 19 21 to July 21 19 21
that I last saw h in alive on July 20 19 21
and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Left Leg. 6 wk
unknown (duration) yra. mos. ds.

CONTRIBUTORY (Secondary) Gas Bacillus Infection (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of —
Was there an autopsy? Not as yet
What test confirmed diagnosis? — M. D.
(Signed)
7/21/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL July 22 1921
Holy Redeemer Cem. — ADDRESS 403 S. Wolfe

20 UNDERTAKER Lilly and Zeiler

B.—WRITE PLAINLY, with ink. AGE should be carefully supplied. Exact statement of AGE should be carefully supplied, so that it may be properly classified. Information should be carefully supplied, so that it may be plain terms, so that it may be properly classified

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55537.

CERTIFICATE OF DEATH.

64 D 55537.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 654 Bradley ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Fields —

(Residence in Baltimore: No. 614 Bradley St. St.: 57 yrs., 1 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Not Known, 1870
(Month) (Day) (Year)

7-AGE, 51 yrs. 5 mos. 0 ds.

If LESS than 1 day, ... hrs. ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Any Kind of Work

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Freeland ?

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Penna Ave

15-

Filed ..... 1921. Robert P. Harrison, Registrar.

JL 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1921, to July 20 1921, that I saw h[illegible] alive on July 19 1921, and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 0 yrs. 0 mos. 16 ds.

CONTRIBUTORY (Secondary) None

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) R. B. Kenny M. D.

July 21, 1921 (Address) 614 Bradley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, July 23, 1921

20-UNDERTAKER Daniel Easton — ADDRESS 916 Penna ne

1.—Every item of information should be carefully given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55538 HEALTH DEPARTMENT—CITY OF BALTIMORE 170 D 55538

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Eastern St ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Gibbons

(a) RESIDENCE. NO. 524 Eastern St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs 11 mos. 22 ds. How long in U. S., if of foreign birth? 72 yrs. 4 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Scrap Yard Mt Clair

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Aggmac Co. Va.

PARENTS

10 NAME OF FATHER Revel Gibbons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Sarah Gibbons 522 Eastern St

15 Filed Robert P. Harrison, Registrar

JUL 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 22 1921 to July 20th 1921.

that I last saw him alive on July 20th 1921.

and that death occurred, on the date stated above, at 2-5P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

endocarditis (duration) yr. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. two mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) D H Evans, M. D.

. 19 (Address) Greene & Franklin Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn Cem July 24 1921

20 UNDERTAKER — ADDRESS

Daniel Easton 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated [illegible]. Exact statement of [illegible] mation should be carefully supplied. AGE should be properly classified. Exact statement of [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] may be [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55539

D 55539

CERTIFICATE OF DEATH.

152

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 97 Kelly Place ST.: 13 WARD)

2-FULL NAME Howard Nelson Patterson

a) RESIDENCE. NO. 97 Kelly Place ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 7 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15/1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Butte city

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Frank H Patterson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Shuster

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mary Shuster

(Address) 97 Kelly Place.

15 Filed Robert P. Harrison, Registrar

JUL 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22. 1921

17 I HEREBY CERTIFY, That I attended deceased from July 21 st 1921, to July 21 st 1921.

that I last saw him alive on July 21 st 1921.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Central primitive. Continuous convulsions for 12 hours, possibly from pressure in birth canal.

(duration) yrs. mos. 12 hrs.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What lest confirmed diagnosis? No

(Signed) H. G. Fuller M. D.

7/22. 1921 (Address) 1527 W. Fay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Mary's Cem. Humpton 7/23/1921

20 UNDERTAKER J WATTER DAVIS

ADDRESS 2307 Pine St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. AGE should be carefully supplied. Exact statement of DATE OF BIRTH should be carefully supplied. AGE should be properly classified. Exact statement of mation should be carefully supplied. AGE should be properly classified. Exact statement of mation should be carefully supplied. AGE should be properly classified. Exact statement of mation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55540

D 55540

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maple Ave., Overlea, Md. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Henry Rivers

(a) RESIDENCE. NO. Maple Ave., Overlea, Md ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Rivers

6 DATE OF BIRTH (month, day, and year) Nov. 14th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Blacksmith)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0006

9 BIRTHPLACE (city or town) Montreal
(State or country) Canada

PARENTS

10 NAME OF FATHER Joseph Rivers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Canada

12 MAIDEN NAME OF MOTHER Margaret Sherwood

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Canada

14 Informant (Address) Miss Sarah V. Rivers 924 Hollins St.

15 Filed JUL 22 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1921, to July 21, 1921, that I last saw him alive on July 20, 1921, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Ch. Art. Nephritis

(duration) yrs. [illegible] mos. ds.

18 Where was disease contracted if not at place of death? 924 Hollins St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 13 or 15 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 23 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bulto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. All information should be stated EXACTLY. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INSTRUCTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55541

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55541

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3040 Belmont Ave ST.: 16 WARD)

2-FULL NAME Annie Crown

(a) RESIDENCE. NO. 3040 Belmont Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion A. Crown

6 DATE OF BIRTH (month, day, and year) Aug 5 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elkridge Md

PARENTS

10 NAME OF FATHER John Kay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince Geo Co Md

12 MAIDEN NAME OF MOTHER Emily Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Morris A. Crown
(Address) 2409 Elmora ave

15 Filed JUL 22 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1921

17 I HEREBY CERTIFY, That I attended deceased from May 29 1921, to July 21, 1921, that I last saw h[illegible] alive on July 21, 1921, and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) 720 N. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Olivet Cem July 23 1921

20 UNDERTAKER Wm J Luckie & Son ADDRESS Norwood Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated [illegible] mation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements on back of certificates. TION is very important. See instructions on back of certificates.

D 55542 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55542

CERTIFICATE OF DEATH.

6 ✓ 104

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 212 n monfard St. WARD)

2-FULL NAME Mckleod Kelly

(Residence in Baltimore: No. 212 Monfard St.; yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Sing.

6-DATE OF BIRTH, Jan (Month) 10 (Day), 1921 (Year)

7-AGE, ... yrs. 7 mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): maryland

PARENTS.

10-NAME OF FATHER: Mose. Kelly

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Annie Johnson

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mose Johnson

(Address) 212 N. Monfard St

15-

Filed ..... 191 .....

Robert P. Harrison,
Registrar.

JL 231921 Burial Permit Clerk

N.B.—Every item of information should be given, so that it may be properly recorded. CAUSE OF DEATH in plain terms, as that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

1-21, 192.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: July 22 1921

20-UNDERTAKER: Milton Davis — ADDRESS: 317 N Eden St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55543

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55543

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 810 (ST.) China (WARD) 22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Brooks

(a) RESIDENCE. NO. 810 China ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. 11 mos. ds. How long in U. S., if of foreign birth? mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about March 1868

7 AGE: Years 52; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Work 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Mary Kelly 1716 Church Ln

15 Filed 7/22/21 Robert P. Harrison, Registrar [Burial Permit Clerk.]

JUL 23 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/21/ 19 21

17 I HEREBY CERTIFY, That I attended deceased from 7/18/ 19 21, to 7/21/ 19 21, that I last saw h alive on 7/21/ 19 21 at 11:30 a m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Apnea (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria - Sclerosis

Anuria (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no clinical

What test confirmed diagnosis?

(Signed) L. Bruce Bowley M. D.

7/22/ 19 21 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Cem

DATE OF BURIAL: July 23 1921

ADDRESS

20 UNDERTAKER: L. V. Brown & Son Westminster

Information should be carefully supplied, so that it may be complete and accurate. Certificate may be prepared in ink or by typewriter, but must be signed in ink. Use black ink. Do not write in margins. Do not fold certificate. CAUSE OF DEATH in plain terms, so that it may be understood by the laity. Do not use abbreviations or technical terms. See instructions on back of certificates. SIGNATURE is very important.

D 55544 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55544

CERTIFICATE OF DEATH.

REGISTERED No. C 119

(PLACE OF DEATH

CITY OF BALTIMORE (No. 15 1/2 Rossbach Court. St. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Israel Boone.(C) 30 yrs., mos., ds.)

(Residence in Baltimore: No. 15 1/2 Rossbach Court.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH, Do not know. (Month), / (Day), ... (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER, Isaac Boone.(C)

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co. Md.

12-MAIDEN NAME OF MOTHER Amelia Brooks.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sally Boone.(C) wife.

(Address) 15 1/2 Rossbach Court.

15- Robert P. Harrison,

Filed ....., 191 ..... Registrar.

23 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22nd. 1921. (Month) (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis,
Uraemiae.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Leonard M. D.

July 22. 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet

DATE OF BURIAL, July 23, 1921

20-UNDERTAKER R. L. Parham

ADDRESS 699 N. Eden St.

N. B.—Every item of information should be carefully supplied. Each item properly classified. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 55545

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55545

CERTIFICATE OF DEATH.

REGISTERED NO. 2328

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hughes

(a) RESIDENCE. NO. 937 Leadenhall st. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed JL 22 1921 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21 . 1921, to July 21. 1921.

that I last saw him alive on July 21. 1921.

and that death occurred, on the date stated above, at 12.25 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Clyde McNeill, M. D.

7-21-21 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 24 19 21

20 UNDERTAKER John H. Trad[illegible] ADDRESS [illegible]

B.—WRITE plainly. Ink should be carefully supplied. Abbreviations may be properly used. Information should be carefully supplied, so that it may be plain terms, so that it may be used for statistical purposes. Every blank must be filled. If unknown, or not applicable, write unknown or the word. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓

D 55546

151

REGISTERED NO.

149 570
D 55546

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.) 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Lumin

(a) RESIDENCE. NO. 1047 Argyle ave ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 28-21

7 AGE: Years | Months | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Lumin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Grace Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mother

15 Filed 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

JUL 23 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19-21, 19..., to July 22, 19 21, that I last saw h.. alive on July 22, 19 21, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Icterus Gravis

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Malnutrition (duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) James C. Fox Jr. M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: July 23 1921

20 UNDERTAKER: Daniel Easton — ADDRESS 916 Park ave

H.—Write should be carefully supplied so that it may be mation should be in plain terms, so that it may be CAUSE OF DEATH in plain terms. See instructions on back of TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55547

D 55547

CERTIFICATE OF DEATH.

REGISTERED NO. C 1779

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 518 Jasper ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Barnes St.: 25 yrs., mos. ds.)

(Residence in Baltimore: No. 518 Jasper

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan (Month) 21 (Day), 1873. (Year)

7-AGE, 48 yrs. 6 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Domestic (b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER. — Collins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin Parker

(Address) 213 N. Mulberry St.

15- Robert P. Harrison, Registrar.

JUL 28 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 22 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14th 1921, to July 22nd 1921.

that I saw h— alive on July 21st 1921.

and that death occurred, on the date stated above at 12 14m

The CAUSE OF DEATH* was as follows: Nephritis

disease

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. mos. 14 ds.

(Signed) [illegible] M. D.

July 22, 1921. (Address) 924 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet

DATE OF BURIAL, July 26, 1921.

20-UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

NB—Every item of information must be given in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D 55548

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55548

CERTIFICATE OF DEATH.

104

REGISTERED NO. C

Duplicate

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 776 Sarah ann ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred E. Stewart

(Residence in Baltimore: No. 776 Sarah ann St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept (Month) 28 (Day) 1920 (Year)

7-AGE, yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, John Stewart

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mable Bear

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Carton

(Address) 916 Pine

15- Filed 9/31 1921 Robert P. Harrison, Deputy Register.

Daniel Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 21 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Food & Heat

(Duration) yrs. mos. 3 ds.

(Signed) W K Gwynn M. D. (Coroner.)

7-23, 1921. (Address) 111 N Dasdge

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn

DATE OF BURIAL, July 23 1921

20-UNDERTAKER Daniel Carton

ADDRESS 916 Pine

N.B.—Every item of information should be carefully supplied. AGE must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Corrected as P July 21-24

D55548. HEALTH DEPARTMENT—CITY OF BALTIMORE D. 55

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 776 Sarah Ann ST., WARD)

(If death o hospital or give its N of street and fill out No.

2-FULL NAME Mildred E Stewart

(Residence in Baltimore: No. 776 Sarah Ann st. St.; yrs., mo

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. .....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nonn.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City Md

PARENTS.

10-NAME OF FATHER, John Stewart

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mable Bear

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July 21, ...
(Month) (Day)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....find that said deceased came to h
on the day stated above.
The CAUSE OF DEATH* was as follows:

.....Gastro Enteritis.....

..... (Duration) .....yrs. 4 days

CONTRIBUTORY (Secondary) Heart Disease

..... (Duration) .....yrs. 4 days

(Signed) W R Gorsuch
(Coroner.)

July 25, 1924 (Address) 117 N. Duran

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUI HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS SIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.

Where was disease contracted, if not at place of death

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BUR

20-UNDERTAKER | ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55549

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55549

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1437 W. Lanvale ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Kirby

(a) RESIDENCE. NO. 1432 W Lanvale ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna M. Kirby

6 DATE OF BIRTH (month, day, and year) Mch. 23, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER May Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Edna M. Kirby

(Address) 1432 W. Lanvale St.

15 Filed JUL 23 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to July 21, 1921, that I last saw him alive on July 20, 1921, and that death occurred, on the date stated above, at 5. 9. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No test made

(Signed) Mrs. L. McCarthy, M. D.

7-21 1921 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	July 23 1921
20 UNDERTAKER John C. Mitchell	ADDRESS 22 N. Smith St

Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55550

D 55550

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 Morling Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edw E. Mulcahy

(Residence in Baltimore: No. 1304 Morling Ave St.; 47 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov (Month) 8 (Day) 1870 (Year)

7-AGE, 6 yrs. 14 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ood

9-BIRTHPLACE, (State or Country), Balto. City.

PARENTS.

10-NAME OF FATHER, Stanford Mulcahy

11-BIRTHPLACE OF FATHER (State or Country) Balto. City

12-MAIDEN NAME OF MOTHER Susie J. Cotter

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanford Mulcahy

(Address) 1304 Morling Ave

15-

Robert P. Harrison,

Filed....., 191.....

Registrar.

7 22 1921 Burial Permit Clerk

N.B.—Every item of information must be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 (Month) 22 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7-20 1921, to 7-22 1921, that I saw h[illegible] alive on 7-22 1921, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

(a) Cardiac Vascular asthenia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. 2 mos. ds.

(Signed) C F Conyngham M. D.

7-22, 1921. (Address) 3 W Ol Rolland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral | DATE OF BURIAL, July 23, 1921

20-UNDERTAKER P. J. Marshall | ADDRESS 355 Fall Ave

Gastro Enteritis.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55551

D 55551

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Maryland Ave ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Amelia Thomas (Resident)

(a) RESIDENCE. NO. 2005 Maryland Ave ST., 12 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 69 yrs. 4 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of B. George Thomas

6 DATE OF BIRTH (month, day, and year) March-4-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) — None

(c) Name of employer — None

9 BIRTHPLACE (city or town) (State or country) — Alexandria Virginia

PARENTS

10 NAME OF FATHER James E. McGraw

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Alex Virginia

12 MAIDEN NAME OF MOTHER Esther Amelia ??

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Georgetown Washington D.C.

14 Informant (Address) Mr Geo. D. Claylor (Nephew) Garrison Bateman Ebe

15 Filed . 19 Robert F. Harrison, Registrar

JUL 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15 . 1920 . to July 22 . 1921 . that I last saw her alive on July 22 . 1921 . and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis and Chronic Endocarditis

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) 10 yrs. mos. ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert L. Mitchell M. D.

July 22 1921 (Address) 211 E Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Alexandria, Virginia — DATE OF BURIAL July 25 1921.

20 UNDERTAKER STEWART & HOUSTON COMPANY ADDRESS 1400 N. NORTH AVE.

(Licensed Embalmer.)

N. B.—WRITE PLAINLY. Blanks must be carefully supplied. Certificate should be carefully supplied, so that it may be properly classified. Information should be in plain terms, so that it may be understood. Physicians are requested to report CAUSE OF DEATH in plain terms. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55552 ✓

D 55552

CERTIFICATE OF DEATH.

150

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Fremont ST., 14 WARD)

2-FULL NAME Floyd McHenry Wood

(a) RESIDENCE NO. 1107 Fremont Ave ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ppd

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Nathaniel Wood

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant Nathaniel Wood

(Address) 1107 Fremont Ave.

15 Filed ..... 19 ..... Registrar

JUL 21 1921 Robert T. [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to July 21, 1921, that I last saw h[illegible] alive on July 20, 1921, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

CONTRIBUTORY (Secondary) Cardiac Asthenia (duration) 1 yrs. mos 25 ds.

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) E Sullivan Frey, M. D.

7-22 1921 (Address) 1928 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 7-23 1921

20 UNDERTAKER Samuel M. Chase Sons — ADDRESS 401 Mosher

N. B.—WRITE PLAINLY, with ink. All items must be properly supplied. Age should be carefully supplied. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55553 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55553

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED NO. C 120

CITY OF BALTIMORE: (No. Provident Hosp- ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Zeta Hearn

(Residence in Baltimore: No. Provident Hosp. 413 W. Biddle St.; yrs. 1½ mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, March (Month) (Day) 1901 (Year)

7-AGE, 20 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Boyds Va

PARENTS.

10-NAME OF FATHER, Bernard Hearn

11-BIRTHPLACE OF FATHER (State or Country), Boyds Va

12-MAIDEN NAME OF MOTHER Clara B. Jones

13-BIRTHPLACE OF MOTHER (State or Country), Boyds Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernard C. Hearn

(Address) Boyds Va

15-

Filed 1921

Robert T. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 23 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11 1921, to July 23 1921, that I saw h m alive on July 22 1921, and that death occurred, on the date stated above, at 3.30A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis (Late Stage).

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. ½ mos. ds.

(Signed) H. Stringer M. D.

7/23, 1921 (Address) 765 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Boyds Va

19-PLACE OF BURIAL OR REMOVAL, Boyds Va P-R R. DATE OF BURIAL, July 23, 1921

20-UNDERTAKER George H Holland ADDRESS 1631 Druid Hill Ave

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55554

D 55554

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1215-E. Lanvale ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Wilcox

(a) RESIDENCE. NO. 1215-E Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life - mos. - ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of Anna T. Wilcox

6 DATE OF BIRTH (month, day, and year) 10/9/1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
61	61	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of Industry, business, or establishment in which employed (or employer) Rosenthal

(c) Name of employer S. Charles St Balto Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John H. Wilcox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Mrs. Maybelle (Address) 1215 E. Lanvale St

15 Filed JUL 23 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 30, 1921, to July 22, 1921, that I last saw him alive on July 21, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 329 Woodyear St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual urinary + B.P.

(Signed) H E Krupp, M. D.

, 19 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery Cem.	July 26 '21

20 UNDERTAKER Geo. J. Ruth ADDRESS 1235 Hanford Ave

mation should be carefully supplied, so that it may be properly coded. CAUSE OF DEATH in plain terms, so that it may be intelligible to the clerk of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55555

CERTIFICATE OF DEATH.

REGISTERED NO. 5 - 176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry D Buckbaum

(a) RESIDENCE. NO. 505 Hillen St. ST., WARD. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conveyancer

(b) General nature of industry, business, or establishment in which employed (or employer) Self - Dr

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Md Baltimore

10 NAME OF FATHER Julius Buckbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Hannah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant (Address) Louis Gradt 1411 Eastern Ave

15 Filed Oct 3 1921 Edna P. Harrison, Registrar

(Special Permit Clerk.)

NOV 2 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1921, to July 21, 1921, that I last saw him alive on July 21, 1921, and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver-regular

Broncitis

CONTRIBUTORY (Secondary) Uremia (duration) 2 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? — (duration) — yrs. — mos. — ds.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) John L. Erwin M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew DATE OF BURIAL July 24 1921

20 UNDERTAKER Jack Lewis 1411 Eastern Ave

ADDRESS

Make entries on this side of certificates. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. INFORMATION is very important.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55556 ✓

D 55556

CERTIFICATE OF DEATH.

6 64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infirmary (WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Susan Harrison

(a) RESIDENCE. NO. Mt. Airy, N. C. ST., WARD. Mt. Airy N. C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER John L. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Martha Cobb.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Mrs. Harrison Mt Airy N. C

15 Filed JUL 23 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to July 23, 1921.

that I last saw h[illegible] alive on July 23, 1921

and that death occurred, on the date stated above, at 6:45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in hospital

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical exam.

(Signed) W. H. Grant, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Airy N. C.	7/23/21

20 UNDERTAKER A. E. Hughes ADDRESS 1 Broadway

mation should be given in answering these questions. Write plainly with ink. Do not use abbreviations or ditto marks. CAUSE OF DEATH in plain terms, so that it may be understood by a physician. Use separate line for each item. DURATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55557

CERTIFICATE OF DEATH.

REGISTERED NO. C 21 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 Sargent ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma E Kilby

(Residence in Baltimore: No. 1316 Sargent St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct (Month) 31 (Day), 19.... (Year)

7-AGE, ...yrs. 8 mos. 2 2 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, James F Kilby

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Osceola Arnal

13-BIRTHPLACE OF MOTHER (State or Country) Baltte md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James F Kilby

(Address) 1316 Sargent St.

15-

Filed ....., 191....

JUL 23 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 22 1921, that I saw h.. alive on July 22 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

(a) Cholera Infantum

(Duration) ....yrs. ....mos. 3w ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

July 23 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. Is the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, July 23 1921

20-UNDERTAKER James Dignan & Son — ADDRESS 1000 S. Paca St

Every item of information must be given so that it may be properly CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

43 55558

D 55558

REGISTERED No.

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 70 Roland Ave. ST. 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Laura Hicks Trumbull

(Residence in Baltimore: No. 70 Roland ave. St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED or DIVORCED (Write the word): Widow

6. DATE OF BIRTH: October (Month) 10 (Day), 1867 (Year)

7. AGE: 53 yrs. 9 mos. 12 ds. If LESS than 1 day, ... hrs. or — min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or country): Lawrenceville. Va

PARENTS

10. NAME OF FATHER: Jude David Stone Hicks

11. BIRTHPLACE OF FATHER (State or country): Virginia

12. MAIDEN NAME OF MOTHER: Martha E. Lewis

13. BIRTHPLACE OF MOTHER (State or country): Virginia

14. THE ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE
(Informant) L. H. Trumbull
(Address) 70 Roland Ave

15. Robert P. Harrison,
Filed ..... 191 Burial Permit Clerk. REGISTRAR

JUL 23 1921

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day), 191X (Year) 21

17. I HEREBY CERTIFY, That I attended deceased from 6-17, 1921, to July 22nd, 1921, that I saw her alive on July 22nd, 1921, and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast and Right arm

(Duration) ..... yrs. 11 mos. 22 ds

Contributory (SECONDARY) Mitral insufficiency

Exhaustion (Duration) ..... yrs. 4 mos. ds.

(Signed) D A Waldram M. D.

....., 191..... (Address) 210 East Preston St,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Petersburg Va — DATE OF BURIAL: 7-24, 1921

20. UNDERTAKER: Stewart N. Perkins Bros Co — ADDRESS: McCulloh & Orchard

N. B.-Every item of information should be carefully supplied. Exact statement may be properly classified. Exact statement CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55559

CERTIFICATE OF DEATH.

D 55559

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5049 Belair Road Cor. Biddison Lane ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Louise Steward

(Residence in Baltimore: No. 5049 Belair Road Cor. Biddison Lane St. Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	

6-DATE OF BIRTH, April (Month) 20 (Day), 1921 (Year)

7-AGE, yrs. 3 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Charles W. Steward

11-BIRTHPLACE OF FATHER (State or Country), Westminster Md.

12-MAIDEN NAME OF MOTHER Laura R. Mobley

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles W. Steward

(Address) 5049 Belair Road

15-

Filed ....., 191.... Registrar.

Robert P. Harrison

JUL 23 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 23 1921, that I saw h[illegible] alive on July 22 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:
Failure to close of Foramen Ovale

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart

(Duration) yrs. mos. ds.

(Signed) Claud Smith M. D.

July 23, 1921 (Address) 4206 Harford Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt. Olivet Cemetery Frederick Md. DATE OF BURIAL, July 24, 1921.

20-UNDERTAKER Fredk. Lassahn & Sons ADDRESS Fullerton Md.

CAUSE OF DEATH in plain terms, so that it can be understood. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

(D) 55560

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1837 Lemon ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Larkin Purdum Jr

(a) RESIDENCE. NO. 1837 Lemon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Larkin Purdum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Magnolia Md

12 MAIDEN NAME OF MOTHER Lucy Mae Brass

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Reisterstown Md

14 Informant (Address) Joseph Larkin Purdum Jr 1837 Lemon St

15 Filed ..... 19 ..... Registrar

JUL 22 1921 Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1921, to July 22, 1921, that I last saw him alive on July 22, 1921, and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James L. Carstensen, M. D.

7/22, 1921 (Address) 1724 L Lemon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	July 23 1921

20 UNDERTAKER ADDRESS

Chenowith & Son Chestnut

mation should be carefully supplied, so that it may be properly entered in the records. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55561

CERTIFICATE OF DEATH.

D 55561

Registered No. C 11 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 904 Brvard St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice R. Fay

(Residence in Baltimore: No. 904 Brvard St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) M

6-DATE OF BIRTH. July 10, 1867 (Month) (Day) (Year)

7-AGE. 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work: nv 37

(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country). Md

PARENTS.

10-NAME OF FATHER. S. Rose

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Fay

(Address) 904 Brvard

15- Robert P. Harrison,

Filed JUL 23 1921, 191.. Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 21, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatty degeneration of heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. S. Culley M. D.

(Coroner)

July 22, 1921 (Address) 1639 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Westminster Md

DATE OF BURIAL. July 23 1921

20-UNDERTAKER Coale

ADDRESS 507 N. Hth

Every item of information should be given, so that it may be property classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55562

D 55562

CERTIFICATE OF DEATH.

REGISTERED NO. 18 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. A. Lindvall

(a) RESIDENCE. No. 8881 W. Lombard st. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos ds How long in U. S., if of foreign birth? Unknown mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tonia Lindvall

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records U.T.H.

15 Filed 11 23 1921 Registrar Robert P. Harrison, Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8 1921, to July 22 1921, that I last saw him alive on July 22 1921, and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. in sputum, X-ray.

(Signed) Clyde M. Neal M. D.

7-23-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL July 25 1921

20 UNDERTAKER Henry H. Witzke ADDRESS 1531 W. Lombard

mation should be entered in plain terms, so that it may be readily understood. CAUSE OF DEATH in plain terms, so that it may be readily understood. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

V5563 D 55563

HEALTH DEPARTMENT—CITY OF BALTIMORE D 55563

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE. NO. 467 Augusta Ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Vernon F. & Edith G Smith.

(a) RESIDENCE. NO. 467 Augusta ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or 30 min.
—	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None 500

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Vernon F. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Edith G Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Vernon F Smith (Address) 467 Augusta

15 Filed JUL 24 1921 ROBERT J. SLATER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1921

17 I HEREBY CERTIFY, That I attended deceased from July 22 . 1921 . to July 22 . 1921 . that I last saw h— alive on July 22 . 1921 . and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edw Cunningham M. D.

7/25 1924 Address) 517 Fidelity Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Loudon Park — DATE OF BURIAL July 23 1921

20 UNDERTAKER — C. W. Dill — ADDRESS 3109 Fredk. Ave:

mation should be carefully ... terms, so that it may be ... CAUSE OF DEATH in plain terms. ... See instructions on back of ... TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55564

D 55564

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 426 Myrtle Ave ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Davis

(a) RESIDENCE. NO. 426 Myrtle Ave ST., WARD. Reisterstown Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE — Years: 88 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): A Sarah Hunter 426 Myrtle ave

15 Filed JUL 24 1921 19 ROBERT F. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18 1921 to July 21 1921. that I last saw him alive on July 20th 1921, and that death occurred, on the date stated above, at 5 30 a. m.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Old age 88 yr

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? His home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General Condition

(Signed) Samuel A Bair, M. D.

19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Reisterstown — DATE OF BURIAL: July 24 19 21

20 UNDERTAKER: James H. Dennis — ADDRESS: 1303 Pennsylvania

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55565

CERTIFICATE OF DEATH.

40 D 55565

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO. 218 N Belnord ave. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles G. Simmon

(a) RESIDENCE. NO. 218 N Belnord ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Rose Simmon

6 DATE OF BIRTH (month, day, and year) October 24 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker 003

(b) General nature of industry, business, or establishment in which employed (or employer) Adolph Schlag

(c) Name of employer 830 E Eager st

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Simmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amalgunda Opel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amalgunda Simmon (Address) 218 N Belnord

15 Filed JUL 24 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June — 2 — 1921 to July 22 1921.

that I last saw h— alive on July 22 1921.

and that death occurred, on the date stated above, at 11:35 a.m.

The CAUSE OF DEATH* was as follows:

Malignant Dis. liver (Carcinoma)

(duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) General & Lawrence (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual symptoms

(Signed) Parker Brunner M. D.

(Address) 125 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL July 1921

20 UNDERTAKER Wendell Dysel & Son ADDRESS 373 Mon

CAUSE OF DEATH in plain terms, so that it may be understood by all. Abbreviations of certificates. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 55566

CERTIFICATE OF DEATH.

REGISTERED NO. 13 120

D 55566

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 4111 Dorsdale Ave ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Adler

(a) RESIDENCE. NO. Rhamney & Lindenfor WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Adler

6 DATE OF BIRTH (month, day, and year) June 12th 1851

7 AGE Years 70 Months 1 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dry Goods. Merch

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr H Adler (Address) 4112 Linden

15 Filed JUL 24 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10th. 1921. to July 22 1921. that I last saw h. alive on July 22 1921. and that death occurred, on the date stated above, at 10 PM m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? W. Va.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Eugene Heyroud, M. D.

19 (Address) 800 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew — DATE OF BURIAL Jul 27 1921

20 UNDERTAKER Harry Sondheim ADDRESS 1184 W Balto St

Burial Permit Clerk

mation should be carefully written in plain terms, so that it may be understood. Do not use abbreviations or technical terms. Be particular and answer each question. If there is no person to answer under any head, write none, or 0. Do not leave any blanks. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55567

CERTIFICATE OF DEATH.

152 D 55567

1-PLACE OF DEATH

REGISTERED No. C 6

CITY OF BALTIMORE: (No. 3103 E Fairmount Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Morgan

(Residence in Baltimore: No. 3103 E Fairmount Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word): Single

6-DATE OF BIRTH, July (Month) 23 (Day) 1921 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 4 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balt.

PARENTS.

10-NAME OF FATHER: William H Morgan

11-BIRTHPLACE OF FATHER (State or Country): St Marys Wd

12-MAIDEN NAME OF MOTHER: Portia Williams

13-BIRTHPLACE OF MOTHER (State or Country): North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H Morgan

(Address) 3103 E Fairmount

15-

Filed ..... JUL 24 1921 ROBERT J. CRAWFORD Registrar. Vital Records Division

N. B. CAUSE OF DEATH in plain terms. ... important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 23 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1921, to July 23 1921, that I saw h[illegible] alive on July 23 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis Pulmonum

4 hours

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Maxwell F Mayer M. D.

July 23, 1921 (Address) 311 S Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Patricks — DATE OF BURIAL, July 25, 1921

20-UNDERTAKER J. A. Moran — ADDRESS 3000 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55568

CERTIFICATE OF DEATH.

50 D 55568

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1536 N. Patterson Park ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick C. Euler

(a) RESIDENCE. No. 1536 N. Patterson Park ave. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE of~~: Nellie B. Euler

6 DATE OF BIRTH (month, day, and year): Oct 31, 1861

7 AGE — Years: 59 — Months: 8 — Days: 23 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Furniture Business

(b) General nature of industry, business, or establishment in which employed (or employer): 145

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jacob Euler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Augusta Ener

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Nellie B. Euler 1536 Patterson Park

15 Filed ..... 19 ..... Registrar

JUL 24 1921 ROBERT I. [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2 1920 to July 23 1921 that I last saw h.. alive on July 22 1921 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Influenza (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edmund Levy M. D.

7/25 1921 (Address) 4132 Wilkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: July 25 1921

ADDRESS: 1739 Eager

20 UNDERTAKER: Zirkler & Zirkler

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55569 ✓ D 55569

D 55569

CERTIFICATE OF DEATH.

1

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 923 S. Curley ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E. Sutherland

(a) RESIDENCE. NO. 923 S. Curley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30. 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	13	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Sutherland

11 BIRTHPLACE OF FATHER (city or town) Charlestown
(State or country) Mass.

12 MAIDEN NAME OF MOTHER Lida Rowe

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Lida Sutherland
(Address) 923 S. Curley St.

15 Filed ..... 19 ..... ROBERT J. KRAUSER Registrar

JUL 24 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17

I HEREBY CERTIFY, That I attended deceased from July 6, 1921, to July 23, 1921, that I last saw h.im alive on July 23, 1921, and that death occurred, on the date stated above, at 9.05 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) — yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) William H. Hyson M. D.

7/23. 1924 (Address) 2016 Guilford ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	July 26 1921
20 UNDERTAKER	ADDRESS
Birkeler & Zirkler	1739 Eager

CAUSE OF DEATH in plain terms, ... TION is very important. See instructions on back of certificate.

D 55570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 120 D 55570

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1138 W Lafayette Av, ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F. Milby

(Residence in Baltimore: No. 1138 W Lafayette Av St.: 9 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	married

6-DATE OF BIRTH, March 15, 1885
(Month) (Day) (Year)

7-AGE, 36 yrs. 4 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Chas. H. Haywood

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed. Milby

(Address) 1138 W Lafayette Av

15- JUL 24 1921 ROBERT P. KRAUTER

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Newman M. D.
(Coroner.)

July 23 1921 (Address) 2032 Edmondson Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, July 25 1921

21-UNDERTAKER Edward Ruggold ADDRESS 1463 N. Carey

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55571 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 29 D 55571

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4001 Woodbine Ave ST.: 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur M. Foos.

(a) RESIDENCE. No. 4001 Woodbine Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Divorced.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43.	4	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Foos Plumbing & Heating Co. Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John C. Foos.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary V. Favier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant John C. Foos
(Address) 4001 Woodbine Ave.

15 Filed JUL 24 1921 ROBERT A. CARTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1921.

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to July 24, 1921, that I last saw him alive on July 23, 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Amerritt Lorell, M. D.

July 24 1921 (Address) 631 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 26 1921
20 UNDERTAKER Geo. W. Little	ADDRESS 2700 Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be certified to by physicians in all parts of the country. Information should be entered on all certificates.
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

14944 D 55572

HEALTH DEPARTMENT—CITY OF BALTIMORE

30 D 55572

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital St. 17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Wilson. H Balto.

(a) RESIDENCE NO. 608 Dolphin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wilson 858 Fifth Ave, N.Y. City

6 DATE OF BIRTH (month, day, and year) Sept. 10, 1902.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	18	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student H.S.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Wilson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hamie Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUL 25 1921 ROBERT J. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18 .1921. to July 22 .1921.

that I last saw h[illegible] alive on July 22 .1921.

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) [illegible] yrs. [illegible] mos. 3 wks

CONTRIBUTORY (Secondary) None Known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal puncture

(Signed) Hugh T. Morgan, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn [illegible]

DATE OF BURIAL July 25 1921

20 UNDERTAKER Samuel S. Lemley

ADDRESS Madison

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55573

D 55573

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norris Stanley (Stanley Norris)

(a) RESIDENCE. NO. 1126 N. Calvert st. ST.,..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) D.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Wash.
(State or country) D.C.

12 MAIDEN NAME OF MOTHER Margaret Tibbets

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JUL 25 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1920, to July 23, 1921, that I last saw him alive on July 22, 1921, and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous arthritis of spine (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray exam.

(Signed) [signature] M. D.

7-23-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL July 25 1921

20 UNDERTAKER Lemuel Wensley ADDRESS [illegible]

CAUSE OF DEATH in plain terms. So that it may be classified. See instructions on back of certificates. TION is very important.

Spec. – 6-9-19 – H. P. Co. – 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55574

D 55574

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hampden Court Apartments (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ellen McGinnis

(a) RESIDENCE. No. Hinder Court Apts St., ... Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. Frank McGinnis.

6 DATE OF BIRTH (month, day, and year): July 20 1857

7 AGE — Years: 64 — Months: 0 — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Thomas Fallon

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Mary Haney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Mrs Ethna M. Ginnis Brown
(Address) Hampton Court Apartments

15 Filed JUL 25 1921 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20 1921 to July 22 1921 that I last saw h.er alive on July 22 1921 and that death occurred, on the date stated above, at 2.15 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Merritt Lorell, M. D.

7/22, 1921 (Address) 631 W. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine — DATE OF BURIAL: July 25 1921

20 UNDERTAKER: Jos B Cook — ADDRESS: 1002 N Balto St

mation should be given in answering these questions, so that it may be understood by the public generally. CAUSE OF DEATH in plain terms, so that it may be understood by the public generally. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55575

CERTIFICATE OF DEATH.

15 V D 55575

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 N. Rose ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.))

2-FULL NAME Baby Reese

(Residence in Baltimore: No. 705 N. Rose St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	

6-DATE OF BIRTH, July 24, 1921. (Month) (Day) (Year)

7-AGE, — yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or 10 mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Fred A. Reese

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary C Bernard

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred. A. Reese

(Address) 705 N. Rose St

15- JUL 25 1921 Filed....., 191.... ROBERT J. KRAUTER Registrar.

CAUSE OF DEATH must be given. If unknown, state. Certificate incomplete unless all important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 24 1921 to July 24 1921. that I saw h/m alive on July 24 1921. and that death occurred, on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia

Asphyxia

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal Toxemia

(Duration) ....yrs. ....mos. ....ds.

(Signed) M. D. (Address 526 N. Carrollton Ave.) 7/24/, 1921

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem. DATE OF BURIAL, July 25 1921

20-UNDERTAKER Jas. L. Miller ADDRESS 2334 Jeffers

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55576

CERTIFICATE OF DEATH.

40 D 55576

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital 28 St.; Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances E. Summer

(a) RESIDENCE. No. 4802 Hamilton Ave St.; Howard Park Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Apr 28. 1919

7 AGE — Years: 2 — Months: 2 — Days: 23 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Frances D. Summer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Boston Mass

12 MAIDEN NAME OF MOTHER: Alma E. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Alma E. Summer
(Address) 4802 Hamilton Ave. Howard Park

15 JUL 25 1921 ROBERT J. [illegible] Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921 to July 21, 1921, that I last saw her alive on July 21, 1921, and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows:

Sarcoma of liver

(duration) 1 yr. 3 mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 1, 21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Emil Holman M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: July 25 1921

20 UNDERTAKER: Mr. Mrs J. W. Zenfel & Son

ADDRESS: 201 W. Fayette St

mation should be carefully written in ink, and may be typewritten. CAUSE OF DEATH in plain terms, so that it may be understood on back of certificates. TION is very important. See instructions on back.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 55577

D 55577

CERTIFICATE OF DEATH. X 176

REGISTERED NO. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland General Hospital 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-FULL NAME David E. D. Morris

(Residence in Baltimore: No. Long Green, Maryland St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	single

6-DATE OF BIRTH, Dec ....., 19..... (Month) (Day) (Year)

7-AGE. about 1 yrs. 7 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Edward Morris

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Viola Zepp

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwd L Tipton

(Address) Hampstead Md

15- JUL 25 1921 [illegible]

Filed....., 191..... Registrar.

N. B.—Every item of information must be given in plain terms, so that it may be property classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July 24 ....., 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
(Hemorrhage from laceration of brain)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Hennessy M. D.
(Coroner.)

July 24, 1921 (Address) 3317 Eastern Ave City

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....
Long Green, Maryland

Former or usual residence Long Green, Maryland

19-PLACE OF BURIAL OR REMOVAL. Hampstead Md

DATE OF BURIAL. July 26 1921

20-UNDERTAKER W J Tucker & Son

ADDRESS North Ave

D 55578

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 91-179 D 55578

(PLACE OF DEATH

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No Not Known Market st & annapolis ave St. 25 WARD)

2 FULL NAME Chas H Severe

(Residence in Baltimore: No. Market st St.; 71 yrs. 4 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: 3 (Month) 11 (Day), 1850 (Year)

7 AGE: 71 yrs. 4 mos. 12 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Chas Severe

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Doley

12 BIRTHPLACE OF MOTHER (State or country): unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maggie M Severe

(Address) 710 Wenans

15 JUL 25 1921 ROBERT J. SLATER

Filed ..... , 191 Registrar

Burial ... w ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 7 (Month) 21 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-8, 1921, to 7-20 1921, that I saw h[im] alive on 7-20, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Heat Stroke

(Duration) ... yrs. ... mos. 14 ds

Contributory (SECONDARY) Bronchio Pneumonia

(Duration) ... yrs. ... mos. 7 ds.

(Signed) Z H Hall M. D.

..... , 191 (Address) 1[illegible] Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Baltimore Cem

DATE OF BURIAL: July 25 1921

20 UNDERTAKER: Wm J Ecker & Sons

ADDRESS: Stock & Av

N. B.-Every item of information should be carefully supplied. Accuracy is necessary. Exact statement of the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of residence is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 55579

D 55579

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1323 N Eden ST.: 9 WARD)

2-FULL NAME Anna V. Medtart

(a) RESIDENCE. NO. 1323 N. Eden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Jesse L Medtart

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Fannie Medtart

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Wm T Moore
(Address) 1323 N Eden St

15 Filed JUL 25 1921 [illegible] Registrar

Registered by [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1921, to July 23, 1921, that I last saw h[illegible] alive on " " 22, 1921, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Right hemiplegia (Cerebral thrombosis)

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage 6

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sigismund Stathmann M. D.

July 23, 1921 (Address) 2214 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 25 1921
20 UNDERTAKER	ADDRESS
Wm J Tickner & Son	Balto Md

CAUSE OF DEATH in plain terms, so that it may be understood by persons not physicians. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 55580 — 79 — D 55580

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1718 d. North St.: 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Francis Patterson

(Residence in Baltimore: No. 1718 W. North ave St.: 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: May 10, 1851 (Month) (Day) (Year)

7 AGE: 70 yrs. 2 mos. 13 ds. — If LESS than 1 day, ... hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): N. J.

PARENTS

10 NAME OF FATHER: Bruce Patterson

11 BIRTHPLACE OF FATHER (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Jane Kreuck

13 BIRTHPLACE OF MOTHER (State or country): N. J.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Owens

(Address) 1718 W North Ave

15 Filed JUL 25 1921 ROBERT J. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 23 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to July 23 1921.

that I saw h[illegible] alive on July 22, 1921.

and that death occurred, on the date stated above, at 9 4/5 a. m.

The CAUSE OF DEATH* was as follows:

Acute Sclerosis myocarditis

Multiple neuritis

(Duration) 7 yrs. mos. ds

Contributory (SECONDARY) Myocarditis — about 2 mo

acute dilatation Heart (Duration) at least 2 yrs. mos. 15 ds.

(Signed) L. L. Bullett M. D.

July 23, 1921 (Address) 2220 Garrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lorraine Cem — DATE OF BURIAL: July 26, 1921

20 UNDERTAKER: Wm. Frickhus Sons — ADDRESS: North Ave

N. B.-Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55581

CERTIFICATE OF DEATH.

20-80

D 55581

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3455 Old Frederick Rd ST.; (WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie E Smith

(Residence in Baltimore: No. 3455 Old Frederick Rd Sr. 59 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Nov (Month) 18 (Day), 1847 (Year)

7-AGE, 73 yrs. 8 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frederick Engle

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Edith J Smith

(Address) 3455 Old Frederick Rd

15-

Filed JUL 25 1921 [illegible] TRUSTEE

Registrar.

CAUSE OF DEATH in plain terms. It is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1920, to July 23 1921, that I saw her alive on several months ago 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Virginia Tertons

1 Year (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old Age

(Duration) yrs. mos. ds.

(Signed) Chas H. Burbert M. D.

July 27 1921. (Address) 1100 W. Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, July 26, 1921

20-UNDERTAKER William Cook — ADDRESS 506 North

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55582

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55582

CERTIFICATE OF DEATH.

REGISTERED NO. 91-126

1-PLACE OF DEATH 1527 N. Spring St

CITY OF BALTIMORE: (No 1527 N. Spring ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millard F. Williams

(a) RESIDENCE. No. 1527 N. Spring ST. 9 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabelle Williams

6 DATE OF BIRTH (month, day, and year) Aug 28 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O.F.D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER David Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Sally Rockefeller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant His wife Isabella (Address) Williams

15 Filed JUL 25 1921 [illegible] Registrar [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1921, to July 23, 1921, that I last saw him alive on July 23, 1921, and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Prostatetis with retention urine (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? His home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. W. Macdonald, M. D.

1921 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 7/26 1921

20 UNDERTAKER William Cook

ADDRESS 502 E Nor

N. B.—WRITE PLAINLY. Words should be spelled out in full. Every question must be answered. If information is not supplied, AGE should be carefully supplied. Exact statement of AGE may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of AGE may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of AGE may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

1449 D 55583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129-091 D 55583

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (WARD) 7

2-FULL NAME Sarah Lowell

(a) RESIDENCE NO. 1817 E Madison St WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of LeRoy Lowell

6 DATE OF BIRTH (month, day, and year) Aug 24 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	49	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Wilks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan ... Stevenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Bureau

15 Filed JUL 25 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from July 16 - 1921. to July 23 1921.

that I last saw h alive on July 23 1921,

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hosp.

Did an operation precede death? yes Date of July 16 - 21

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy

(Signed) T. S. Dougherty M. D.

7-24-21 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	7/24 1921
20 UNDERTAKER William Cook	ADDRESS 502 E Watts

mation should be given in plain terms, so that it may be understood by persons generally. Do not use abbreviations or technical terms. CAUSE OF DEATH in plain terms, so that it may be understood by persons generally. Do not use abbreviations or technical terms. CAUSE OF DEATH is very important. See instructions on back of certificates.

Wolf Cohen

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55584 REGISTERED No. C

D 55584

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3527 Reisterstown St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wolf Cohen 36 St.; yrs., mos. ds.)

(Residence in Baltimore: No. 3527 Reisterstown

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Widower

6-DATE OF BIRTH, May 1 (Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailoring
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE. (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Leurs

(Address) 1411 E Balt

15- JUL 25 1921 Filed ....., 191.... [illegible] Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Lee Hamburger M. D. (Coroner)

July 24, 1921 (Address) 3132 Rotunda

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Lehren Hebrew Cem DATE OF BURIAL, July 26 1921

20-UNDERTAKER Jack Leurs ADDRESS 1411 E Balt

N. B.—Every item of information should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

55585 — 109 D 55585

55585
1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Hebrew Hosp ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Barenfeld

(a) RESIDENCE. NO. 432 Aisquith ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1411 E Baltimore

15 JUL 25 1921 ROBERT P. BRADLEY
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-23—, 1924, to 7-25-21, 19—,
that I last saw h— alive on 7-25, 1921,
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Strangulated Hernia
Intestinal Obstruction (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-23-21
Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Louis Sachs, M. D.
7-25, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Nursing Home	July 25 1921

20 UNDERTAKER — ADDRESS
Jack Lewis 1411 E Balto

CAUSE OF DEATH in plain terms, abbreviations not allowed. Information on back of certificates. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55586

CERTIFICATE OF DEATH.

134 D 55586

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No St. Agnes Hosp. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Irene Sawers.

(a) RESIDENCE. NO. 1401 Division ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~ 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER George Sowers

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md " "

12 MAIDEN NAME OF MOTHER Nellie Naylor

13 BIRTHPLACE OF MOTHER (city or town) Balto " (State or country) Md

14 Informant Mary L. Naylor (Address) 1013 Ridgely St

15 JUL 25 192 [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24-21

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1921, to July 24, 1921.

That I last saw her alive on 7-24-21, 19 .

and that death occurred, on the date stated above, at 9.50 A m.

The CAUSE OF DEATH* was as follows:

Pernicious vomiting of pregnancy

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Insanition

(duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? microscopic

(Signed) Dudley P. Boche, M. D.

, 19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

London Park July 25 1921

20 UNDERTAKER — ADDRESS

Martin Fahey & Sons 1827 W North Ave

CAUSE OF DEATH in plain terms, so that a correct classification may be made. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55587

CERTIFICATE OF DEATH.

104 D 55587

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 N Universal Ave St.. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Stuart.

(a) RESIDENCE. NO. 14 N Universal Ave St.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Vaughn
(Address) 1401 Denison

15 JUL 25 19 ROBERT J KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1921, to July 23, 1921, that I last saw him alive on July 23, 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas H Claughton M. D.

(Address) 1504 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL July 25 1921

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1827 W North Ave

mation should be given in these certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55588

D 55588

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH. CITY OF BALTIMORE. (No. 1195 Chas. Mary. St. Mc Gaury 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 1195 N Fulton Ave.,

(Residence in Baltimore: No. 1195 N Fulton Ave St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word)
Female	White	Single

6-DATE OF BIRTH. July (Month) 15 (Day) 1921 (Year)

7-AGE. yrs. mos. 8 da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Chas Mc Geary

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Margaret Stansbury

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Mc Geary

(Address) 1195 N Fulton Ave.

15-

Filed JUL 25 1921 191 ROBERT J. KRAUL Registrar

Baltimore City Health Dept.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1921, to July 22 1921, that I saw h-er alive on July 21 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) yrs. mos. 8 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) Ralph Lloyd M. D.

7/23, 1921. (Address) 726 E Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL — DATE OF BURIAL, JUL 25 1921

20-UNDERTAKER — ADDRESS

Commissioner of Health.

per Wm. F. Woosley

CAUSE OF DEATH to be plainly written. Every item important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55589 CERTIFICATE OF DEATH.

91 D 55589

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter McCann

(a) RESIDENCE. NO. 900 Abraham St. ST., ... WARD.
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos ..... ds
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876 ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45 ?			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.
(Address) New City Hospital.

15 Filed JUL 25 1921 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 18 . 19 21. to July 19 . 19 21. that I last saw h im alive on July 18 . 19 21. and that death occurred, on the date stated above, at 6:00 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?.

Did an operation precede death? no Date of

Was there an autopsy? ~~yes~~ no.

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

7/19/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUL 25 1921

20 UNDERTAKER Commissioner Health,
Per Wm. E. WOODALL

ADDRESS

mation should be carefully supplied. [illegible] that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

265

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109

D 55590

REGISTERED NO. D 55590

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1613 Hanover ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J Pitcher

(a) RESIDENCE NO. 1613 Hanover ST.. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of): late Catherine Pitcher

6 DATE OF BIRTH (month, day, and year): Feb. 2, 1858

7 AGE: Years 63; Months 5; Days 20; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: R R Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harpers Ferry W. Va

PARENTS

10 NAME OF FATHER: Thomas Pitcher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harpers Ferry W. Va

12 MAIDEN NAME OF MOTHER: Catherine Koontz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hedricks Md

14 Informant (Address): Jno Pitcher 1612 Hanover.

15 FILED JUL 25 1921 ROBERT I. [illegible] Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 21

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1921, to June 22, 1921, that I last saw h alive on June 22, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Ephanctan (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: July 25 1921

20 UNDERTAKER: Mrs E C Evans & Sons — ADDRESS: 1428 Charles St

Information should be given in plain terms, so that it may be understood by the general public. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55591

CERTIFICATE OF DEATH.

D 55591

REGISTERED NO. C 1650

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2520 Mosher ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence N. McCullough

(Residence in Baltimore: No. 2520 Mosher st St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, June (Month) 12 (Day), 1880 (Year)

7-AGE, 41 yrs. 1 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Butcher (b) General nature of industry, business, or establishment in which employed (or employer) Dealer

9-BIRTHPLACE, (State or Country), Balto. city, Md

PARENTS.

10-NAME OF FATHER, Edward McCullough

11-BIRTHPLACE OF FATHER (State or Country), Washington D.C.

12-MAIDEN NAME OF MOTHER Susan Roe

13-BIRTHPLACE OF MOTHER (State or Country), Balto. city. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary McCullough

(Address) 2520 Mosher St

15- Filed JUL 25 1921 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1921, to July 24 1921, that I saw h m alive on July 24 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. 2 mos. ds.

(Signed) W. F. Love M. D.

(Address) 836 W. Mont a

July 25 1921

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loraine

DATE OF BURIAL, July 27, 191...

20-UNDERTAKER Geo. W. Little

ADDRESS 2700 Edmondson ave

N. B.—Every item of information must be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D 55592

HEALTH DEPARTMENT—CITY OF BALTIMORE

Juszynski

D 55592

CERTIFICATE OF DEATH.

REGISTERED NO. C 74

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1914 Eastern Ave ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1B)

2-FULL NAME Stanislaus Juszynski

(Residence in Baltimore: No. 1914 Eastern Ave St.; yrs. 22 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept (Month) 22 (Day) 1898 (Year)

7-AGE, 22 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Saloon
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER, John Juszynski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Dobrzynska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Juszynski

(Address) 1914 Eastern Ave

15- FILED JUL 25 1921 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to [illegible]th on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Chas Lyon (Coroner) Emerg M. D.

7/25, 1921 (Address) 1004 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, July 26, 1921

ADDRESS

20-UNDERTAKER John M Weber 1803 Bank st

N. B.—Every item of information should be given in plain terms, so that it may be plainly understood. In CAUSE OF DEATH in plain terms, so that it may be plainly understood. In CAUSE OF DEATH in plain terms, so that it may be plainly understood. In CAUSE OF DEATH

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55593

CERTIFICATE OF DEATH.

45 D 55593

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. St. Agnes Hosp. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Barbary Boecart.

(a) RESIDENCE. No. 2501 N. Pratt St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? —— yrs. —— mos. —— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Boecart.

6 DATE OF BIRTH (month, day, and year) Dec-20 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45 yrs.	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —— 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs. Barbary Boecart.

(Address) 2501 N. Pratt St.

15 Filed JUL 25 1921 ROBERT P. LAMOTTE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24 1921

17 I HEREBY CERTIFY, That I attended deceased from 11-30- 1920, to 7-24 1921, that I last saw h[illegible] alive on 7-24 1921, and that death occurred, on the date stated above, at 9 45 4 m.

The CAUSE OF DEATH* was as follows:

Carcinoma antrum

(duration) 1 yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) Metastases to lungs & stomach (duration) — yrs. 7 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-1-20.

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Dudley P. Bowe M. D.

. 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery DATE OF BURIAL 1924

20 UNDERTAKER: F. B. Keppert ADDRESS 2236 Fredk Ave

mation should be given in answering these questions. CAUSE OF DEATH in plain terms, so that it may be understood. Do not use abbreviations or technical terms. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55594

CERTIFICATE OF DEATH.

159 D 55594

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 602 E Boud St. ST. 3 WARD)

REGISTERED NO C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Novak,

(Residence in Baltimore: No. 606 E. Boud St. 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Unknown, 1 .....
(Month) (Day) (Year)

7-AGE 29 about yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Zoyka

(Address) 606 E. Boud St.

15-

FILED JUL 25 1921 191 ROBERT J. KRAUS Registrar.

Burial Permit Gi...

N. B.—Every item of information should be given in CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 21, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound
Suicide
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock,
(Duration) yrs. mos. ds.

(Signed) F. E. Blades M. D.
(Coroner.)

July 21 191 (Address) 143 N. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary | DATE OF BURIAL, July 25, 1917

20-UNDERTAKER William Fralsovich | ADDRESS 618 Eastern ave.

[illegible] Suicide
32 Cal Reports

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55595

CERTIFICATE OF DEATH.

D 55595

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1113 Ridgely ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roberta B. Horn

(a) RESIDENCE. NO. 1113 Ridgely ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward S Horn

6 DATE OF BIRTH (month, day, and year) March 12 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Winchester Va

9 BIRTHPLACE (city or town) (State or country) Winchester Va

PARENTS

10 NAME OF FATHER James B Dooley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Winchester Va

12 MAIDEN NAME OF MOTHER Sarah C Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Winchester Va

14 Informant William E Dooley (Address) 1617 Clarkson St

15 Filed JUL 25 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 24, 1921, to July 24 1921, that I last saw him alive on July 22 1921, and that death occurred, on the date stated above, at 5:20 a m.

The CAUSE OF DEATH* was as follows: Vascular lesion of heart

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Examination

(Signed) A Mann, M. D.

, 19 (Address) 1216 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Cedar Hill Cemt July 26 1921

20 UNDERTAKER — ADDRESS

Wm Cook 502 E North Ave

N. B.—While ... should be carefully supplied. AGE should be properly classified. Exact statement of DECEASED'S mation should be carefully supplied. AGE should be properly classified. Exact statement of DECEASED'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DECEASED'S TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55596

CERTIFICATE OF DEATH.

D 55596

REGISTERED NO. 2779

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 811 Belgium Ave. (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Athman.

(a) RESIDENCE NO. 811 Belgium Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Elizabeth Athman.

6 DATE OF BIRTH (month, day, and year) Oct 25 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker.

(b) General nature of industry, business, or establishment in which employed (or employer) 617

(c) Name of employer Retired.

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Don't Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Matilde Kuhn. (Address) 811 Belgium Ave

15 Filed JUL 25 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to July 24, 1921.

that I last saw him alive on July 24, 1921,

and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH* was as follows:

Heart disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Heart disease

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Young Winbrook, M. D.

July 24 1921 (Address) 611 Hanover Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer.	July 26 1921

20 UNDERTAKER Wm Cook 502 E. Hamburg ADDRESS

Burial Permit Given

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Edward Zekiel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 149630
D 55597.

CERTIFICATE OF DEATH.

30

D 55597.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital (ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Zekiel.

(a) RESIDENCE No. 521 South Decker Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ahild 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Leon Zekil.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Piotrowski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Johns Hopkins Hospital
(Address) Records.

15 Filed JUL 25 1921 19 ROBERT I. KRAUTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1921, to July 24, 1921, that I last saw him alive on July 24, 1921, and that death occurred, on the date stated above, at 2.25 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) James C. Fox, Jr M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Grm., DATE OF BURIAL July 26" 1921.

20 UNDERTAKER M. F. Sadowski, ADDRESS 405 S Ann

mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55598

D 55598

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH — Forest Park

CITY OF BALTIMORE: (No. 3415 Fairview Ave ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes V. Horner

(a) RESIDENCE. NO. 3415 Fairview Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John R Horner

6 DATE OF BIRTH (month, day, and year) Nov 19, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Blacklar

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Engleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Albert N Horner 3415 Fairview Ave

15 Filed JUL 25 1921 ROBERT S. KRAUTER Registrar

JUL 25 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from ..., 1919, to July 23, 1921, that I last saw h[illegible] alive on July 22, 1921, and that death occurred, on the date stated above, at 11 40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-Sclerosis.

Chronic Interstitial Nephritis

(duration) 3 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Sclerosis Mitral valve.

Nephritis (duration) 2 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical-Microscopic

(Signed) Glenn S. Burhoop, M. D.

, 19 (Address) 930 N. Calvert st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	July 26 1921
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette St

N. B.—WHITE PLAINLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55599 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55599

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. ST.: 18 WARD) REGISTERED No. 108

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phil Piquett

(a) RESIDENCE. No. 405 Carrollton Ave ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Piquett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Louise Tipp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Pa.

14 Informant Mrs Piquett (Address) 405 Carrollton Ave

15 Filed JUL 25 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1921, to July 25, 1921, that I last saw him alive on July 25, 1921, and that death occurred, on the date stated above, at 5.00 a m.

The CAUSE OF DEATH* was as follows:

acute appendicitis
(Ruptured)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July, 22, 1921

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Howard Matheson Bobert, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Cathedral Cemy	July 27, 1921
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55600

CERTIFICATE OF DEATH.

42 D 55600

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) 20 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Morton

(a) RESIDENCE. NO..... 2025 Hollins Ave St.

(Usual place of abode) Ward.

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	N.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7-1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40 yrs.	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Miss Susa Morton

(Address) 2025 Hollins.

15 Filed JUL 25 1921 ROBERT I. KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-29, 1921, to 7-24, 1921.

that I last saw her alive on 7-24, 1921.

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix of Uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Recto Vaginal Fistula

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dudley P. Bowe. M. D.

. 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL 7/26 1921

20 UNDERTAKER Chas. J. Evans & Son ADDRESS 118 N. Nat'l Ave

N. B.—WRITE PLAINLY, with ink. Information should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55601.

CERTIFICATE OF DEATH.

D 55601

REGISTERED NO. 1479

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1523 Eutaw Place ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. O'Connor

(a) RESIDENCE. NO. 1523 Eutaw Place ST.. WARD.

(Usual place of abode) Baltimore

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? Baltimore yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris O'Connor 1843

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
78				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Dennis Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Tanguey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Elenora Possagno

(Address) 1523 Eutaw Place.

15 JUL 25 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1921. to July 24 1921.

that I last saw h alive on July 24 1921.

and that death occurred, on the date stated above, at 6P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis -

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (secondary) Myocarditis - Edema of Lungs (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) J. Fred Lentz M. D.

7/25. 1921 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL 7/26/ 1921

20 UNDERTAKER C. F. Evans & Son ADDRESS 116 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly certificated. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D 55602 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55602

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (NO. Fort McHenry Baltimore ST. Md. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Wood

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST. Fort McHenry WARD Baltimore Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Robert Wood

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs or ... min.
29yrs	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar
(Address) US PHS Hosp. #56 Ft McHenry Md.

15 Filed ..., 19 ... Registrar

JUL 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to July 23, 19 21.

that I last saw him alive on July 23, 19 21.

and that death occurred, on the date stated above, at 12'20 A.M.

The CAUSE OF DEATH* was as follows: Tuberculosis chronic pulmonary far advance & active

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Lab. report Clinic RP

(Signed) Thomas R. Payne M. D.

, 19 (Address) Senior Surgeon (P) U.S. PHS Hosp. #56 Ft McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md. Mt. Auburn Cemetery

DATE OF BURIAL July 25 1921

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1234 Eutaw St.

mation should be carefully supplied. Avoid abbreviations. Write plainly in ink. Do not use lead pencil. Any physician willfully making a false statement in the CAUSE OF DEATH in plain terms, so that it may be properly classified. Each certificate should be signed and dated as soon as death occurs. Burial Permit cannot be issued unless the CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 55603

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55603

CERTIFICATE OF DEATH.

X 28

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore St. 24 (40 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Kijak

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST., Fort McHenry WARD, Baltimore Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) ----

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or min.
	29 yrs	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster 1923

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar
(Address) US. PHS Hosp. #56 Ft. McHenry Md.

15 Filed ..... 19 .....
Robert P. [illegible]
Burial Permit Clerk. Registrar

JUL 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1921, to July 23, 1921, that I last saw him alive on July 23, 1921, and that death occurred, on the date stated above, at 10'55 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far adv. & active

from Obsdon
(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirm diagnosis? Lab & Clinic report

(Signed) Thomas R Cayce, M. D.

, 19 (Address) Senior Surgeon (C) US. PHS Hosp. #56 Ft McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa

DATE OF BURIAL July 25 1921

20 UNDERTAKER Sol Hunter

ADDRESS 1127 E. Balto St

B. White ... should be carefully supplied. AGE ... mation should be properly classified. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T - 1500 Blks.

(See attached Letter)

D 55604

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55604

CERTIFICATE OF DEATH.

X 28

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore St., 24 39 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cacil Campbell

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST. Fort McHenry Baltimore Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
36. G H Grace 86 yrs.	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) West Indies

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar

(Address) US. PHS Hosp. #56 Ft. McHenry Md.

15 Filed JUL 25 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1921 to July 23 1921.

that I last saw him alive on July 23 1921,

and that death occurred, on the date stated above, at 10'50 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far Adv. active

Thirty Hours (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Lab & Clinic report

(Signed) Thomas R Sayre M. D.

Senior Surgeon (P)

, 19 (Address) US. PHS Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL July 26, 19 21

20 UNDERTAKER Sol Levinson

ADDRESS 127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated mation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

ecl Campbell.

U.S.P.H.S.HOSP.#56,
Ft. Mc Henry, Md.

OFFICE OF
MEDICAL OFFICER IN CHARGE

TREASURY DEPARTMENT

UNITED STATES
PUBLIC HEALTH SERVICE

January 11, 1922.

Commissioner of Health,
Health Department,
Baltimore, Md.

Sir:

Referring to your letter of January 10,1922, relative to letter written you by the Administrative Assistant, M. L. Cole, requesting that you change the age on death certificate of Cecil Campbell, who died at this institution, July 23, 1921, from 26 years to 36 years, I would request that this change be made, as it was evidently a typographical error in recording the age, and a resurvey of the Clinical Record in this case proves the fact, that the man is 36 years of age.

Hoping this will meet with your approval.

Respectfully,
F. N. Gordon
F. N. Gordon,
Surgeon(Reserve),
Medical Officer in Charge.

55604

FNG
FLC:BRB

Spec.—1-10-21—M&T—1500 Bks.

D 55605

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55605

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3428 Dillon ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Donohue

(a) RESIDENCE NO. 3428 Dillon ST., 26 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22 - 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 600

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John J. Donohue

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Mary E. Wissner

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant John J. Donohue
(Address) 3428 Dillon St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

JUL 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1921, to July 24, 1921, that I last saw him alive on July 24, 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Spina Bifida
of Lumbar Spine

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY .....
(Secondary)

.....(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A H B Tilhaus, M. D.

7/25/1921 (Address) 315 S. Bayland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross Cem Harford Rd. DATE OF BURIAL July 25 1921

20 UNDERTAKER Lilly & Zirkin ADDRESS 403 S Wolfe St

...mation should be carefully supplied. ...CAUSE OF DEATH in plain terms, so that it may be ...TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 55606

D 55606

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 25 WARD)

2-FULL NAME Mrs. Catherine Bent

(a) RESIDENCE. NO. Cabin Branch Curtis St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 11, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Sydney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Friend. Mercy Hospital (Address)

15 Filed . 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1921, to July 24, 1921, that I last saw her alive on July 24, 1921, and that death occurred, on the date stated above, at 12:20 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy Paralysis

Followed by cystitis

& Bronchopneumonia

(Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) John J. Ford, M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL July 27 1921

20 UNDERTAKER Lilly and Zeiler

ADDRESS 603 S. Howard.

JUL 25 1921 Burial Permit Clerk.

Make sure that every item is filled in. CAUSE OF DEATH in plain terms, so that it may be correctly coded. OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55607

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55607

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH Church Home & Infirmary REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katie C. Quick

(a) RESIDENCE. No. 3365 Chestnut ave. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry J. Quick

6 DATE OF BIRTH (month, day, and year) Oct 22, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs R C McCleary (Address) Chestnut Ave.

15 Filed 25 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1921, to July 23, 1921, that I last saw h[illegible] alive on July 23, 1921, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Obstruction of Intestines

(duration) 24 hrs yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendix Abscess & Ulcers of Intestines Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3365 Chestnut ave. City

Did an operation precede death? yes Date of July 23. 21

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) H. D. Noble, M. D.

. 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	July 26 1921
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut Ave

mation should be given in answer to each question. CAUSE OF DEATH in plain terms, so that it may be understood by the general public. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55608

D 55608

CERTIFICATE OF DEATH.

1879

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 W. Lexington ST.; 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Tomlin

(a) RESIDENCE. NO. 1013 W Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col'd	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) — 041

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Tomlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edna Ward
(Address) 1013 W Lexington St

15 Filed JUL 25 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1921, to July 23, 1921, that I last saw her alive on July 23, 1921, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Moorman, M. D.

July 24 1921 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	July 26 1921

20 UNDERTAKER Thomas Freeland & Schroder ADDRESS 114 N

Information should be carefully written in ink, so that it may be plainly read. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This information is very important.

(Weikert)

D 55609 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55609

CERTIFICATE OF DEATH 172

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital 26 ST.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis G. Weikert

(Residence in Baltimore: No. 3508 E. Pratt. St.; yrs., 83 mos. 1 ds. 3)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Wh.	Mar'd

6-DATE OF BIRTH, June 6, 1838
(Month) (Day) (Year)

7-AGE, 83 yrs. 1 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cashier at 086
(b) General nature of industry, business, or establishment in which employed (or employer) Dr. stables

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Martin Weikert

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Louis G. Weikert

(Address) 3508 E. Pratt St

15-

Filed ..... 1921 Robert P. Harrison. Registrar.

JUL 25 1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia (Duration) 7 Dys. yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. K. Donley (Coroner.) M. D.

....., 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Mem.	July 26, 1921

20-UNDERTAKER W. M. Cantwell ADDRESS 2839 Cayton Ave.

CAUSE OF DEATH in plain terms, as this is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 55610

D 55610 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 S. Collington Ave ST., 1 WARD)

2-FULL NAME Stephen D. Hellslager

(a) RESIDENCE NO. 17 S. Collington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Hellslager

6 DATE OF BIRTH (month, day, and year) Jan 26, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Landlord

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 20 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Maggie Hellslager

(Address) 17 W. Collington Ave

15 Robert P. Harrison, Registrar

JUL 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 5 , 19 21 , to July 25 , 19 21 ,

that I last saw him alive on July 25 , 19 21 ,

and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

Bronchopneumonia 2 mos ds.

(Duration)

CONTRIBUTORY (Secondary) Tuberculosis over yrs. mos. ds.

(Duration)

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Frankenfield M. D.

19 (Address) 1929 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem.

DATE OF BURIAL July 27 19 21

20 UNDERTAKER H. Sander Sons

ADDRESS

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55611 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55611

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Schoebelein

(a) RESIDENCE. NO. 3108 E. Balto ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Schoebelein

6 DATE OF BIRTH (month, day, and year) June 29, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Steigler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaretha Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christian Schoebelein (Address) 3108 E. Balto St.

15 Filed JUL 25 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to July 27, 1921, that I last saw her alive on July 27, 1921, and that death occurred, on the date stated above, at 2. P. m.

The CAUSE OF DEATH* was as follows:

Uremia OVER

Chronic Gall Bladder Disease

(duration) 2 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/22/21

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms & Operation

(Signed) Frank E. Martin, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	July 27 1921
20 UNDERTAKER	ADDRESS
H. Sauder Sons	1710 N Cal St

MAKING FALSE STATEMENTS IN CAUSE OF DEATH in plain terms, so that a correct classification may be made. ATTENTION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, [illegible] laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not malignant.

Spec.—1-10-21 M&T 1500 Bks.

D 55612 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1442 Presstman ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Anderson

(a) RESIDENCE NO. 1442 Presstman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1st 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Home work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Amelia Co Va.

PARENTS

10 NAME OF FATHER Hunk Anderson

11 BIRTHPLACE OF FATHER (city or town) Amelia Co (State or country) Va.

12 MAIDEN NAME OF MOTHER Virginia Jackson

13 BIRTHPLACE OF MOTHER (city or town) Amelia Co (State or country) Va

14 Informant Laura Jackson
(Address) 1442 Presstman St

15 Filed , 19 Robert P. Harrison, Registrar

25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17

I HEREBY CERTIFY, That I attended deceased from July , 1921 , to July 24 , 1921 , that I last saw her alive on July 24 , 1921 , and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey M. D.

7/25, 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gilmor Hill and Old

DATE OF BURIAL July 26, 1921

20 UNDERTAKER James H Lewis

ADDRESS 1303 Pennsa Ave

CAUSE OF DEATH in plain terms, so that it may be understood by persons not familiar with the use of certificates. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55613

CERTIFICATE OF DEATH.

113

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 N. Carrollton ave ST.) 18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Watts

(Residence in Baltimore: No. 15 N. Carrollton ave St.; 57 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH. Not Known, (Month) (Day) 1864 (Year)

7-AGE. 57 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country). Balto, Md

PARENTS.

10-NAME OF FATHER. Christian Weller

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Mary Lupton

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna Jones

(Address) 1609 W. Franklin St

15- JUL 25 1921

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24 (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1921, to July 25 1921, that I saw her alive on July 23 1921, and that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 6 mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) Jas E. Jones M. D.

July 25 1921 (Address) 1122 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cemy. DATE OF BURIAL. July 26, 1921.

20-UNDERTAKER Jos Foerderers Son ADDRESS 217 S. Paca

CAUSE OF DEATH. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55614

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55614

CERTIFICATE OF DEATH.

REGISTERED NO. 1879

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 W. Lexington St. WARD) 18

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Brown

(a) RESIDENCE. NO. 822 W. Lexington St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda Brown

6 DATE OF BIRTH (month, day, and year) Jan 25 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer H. Gause Bros

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Christian Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amanda Brown (Address) 822 W. Lexington

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from February 19 15. to July 23 1921.

that I last saw him alive on July 13 1921.

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

general arterio-sclerosis.
Cardiac complications

over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) general arterio-sclerosis (duration) 6 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herbert Schonwisch, M. D.

19 (Address) 1134 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 26 1921
20 UNDERTAKER Jos Snowden's Son	ADDRESS 2178 Pa

CAUSE OF DEATH in plain words. See instructions on back of certificates. TION is very important.

JUL 25 1921 Burial Permit Clerk.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal cerebral hemorrhage. Mitral regurgitation. Leaky Valves of heart. Dilated heart.

Spec.—1-10-21—M&T—1500 Blks.

149548 D 55615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55615

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Komoda.

(a) RESIDENCE NO. 2044 Fountain St City. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND OF~~ ~~OR WIFE OF~~ Katy Komoda. (mother).

6 DATE OF BIRTH (month, day, and year) July 18 1921.

7 AGE Years — Months — Days 10 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER James Komoda

11 BIRTHPLACE OF FATHER (city or town) Poland.
(State or country)

12 MAIDEN NAME OF MOTHER Zoloc.

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant (Address) Johns Hopkins Hospital Records

15 JUL 25 1921 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18 .1921. to July 25 .1921.

that I last saw her alive on July 25 .1921.

and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Birth

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George M. Tyson, M. D.

, 19 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL July 26 1921

20 UNDERTAKER John M. Weber ADDRESS 1803 Bank

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55616 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55616

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 S Fremont St. 21 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Bowers

(a) RESIDENCE. No. 808 S. Fremont St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick J Bowers

6 DATE OF BIRTH (month, day, and year) Jan 31, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredk Co Md

12 MAIDEN NAME OF MOTHER Emma Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A A Co Md

14 Informant (Address) Mrs. Clara Harrington 808 S Fremont Ave

15 Filed JUL 25 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from June 13 1921 to July 23 1921 19..., that I last saw h/r alive on July 23 1921 19..., and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) E L Brayton, M. D.

(Address) 301 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	19
20 UNDERTAKER	ADDRESS
Wm J Tuckwell Sons	North & Pa

MAKE ENTRIES IN INK. CAUSE OF DEATH in plain terms, so that it may be properly classified. Use only standard certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Use only standard certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55617

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 W Lanvale ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Kent Co. Md

2-FULL NAME Mary Annie Vickers

(a) RESIDENCE. No. 1932 W. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Vickers

6 DATE OF BIRTH (month, day, and year) Sept 26 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton Md

PARENTS

10 NAME OF FATHER John Ozman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER — Pickering

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edw O. Vickers
(Address) 1932 W. Lanvale

15 Filed Robert P. Harrison, Registrar

JUL 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1921, to July 24, 1921.

that I last saw h[illegible] alive on July 23, 1921.

and that death occurred, on the date stated above, at 4 20 9 m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. Suddenly mos. ds.

CONTRIBUTORY (Secondary) Heat exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Bamman and Lond, M. D.

7/24, 1921 (Address) 626 N Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul Kent Co Md — DATE OF BURIAL July 26 1921

20 UNDERTAKER Wm J Pickus & Son — ADDRESS Natl & Pa

IT may be PROPERLY CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55618

CERTIFICATE OF DEATH.

28

D 55618

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3414 Barclay St. 12 (Ward)

2-FULL NAME Gordon Henry Taylor

(a) RESIDENCE. No. 3424 Barclay St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Helen Taylor

6 DATE OF BIRTH (month, day and year): December 2nd 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Cigarette mfg.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Salisbury Md

PARENTS

10 NAME OF FATHER: Lloyd W. Taylor.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Laura Fuller.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: J. O. Hill

(Address): 2424 Barclay

15 Filed: Robert P. Harrison, Registrar

Burial Permit Clerk.

L 25 1921

CAUSE OF DEATH on back of certificate. TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from October 15th 1920, to July 24th 1921.

that I last saw him alive on July 24th 1921.

and that death occurred, on the date stated above, at 9.25 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? City.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. Uberg-Strand M.D.

7/25/21 (Address) 401 E 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lakeside Cemetery Dover Del

DATE OF BURIAL: July 27 1921

20 UNDERTAKER: Geo J Smith

ADDRESS 1000 N Payette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55619

D 55619

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital, St.; 19 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Burt

(a) RESIDENCE. No. 1844 Mc Henry St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? 9 yrs. 2 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May-18-1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9 yrs.	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer): 600

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): " Holland

12 MAIDEN NAME OF MOTHER: Mary Donaldson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. " Md

14 Informant (Address): Mrs. Mary Burt 1844 Mc Henry St.

15 Filed Robert P. Harrison, Registrar

JUL 25 1921 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24 1921

17

I HEREBY CERTIFY, That I attended deceased from 7-16, 1921, to 7-24, 1921, that I last saw h-- alive on 7-24, 1921, and that death occurred, on the date stated above, at 2 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Mitral insufficiency
Myocardial insufficiency
Endocarditis (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Dudley P. Bowie. M. D.

. 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery DATE OF BURIAL July 26 1921

20 UNDERTAKER: George E. Johnston & Bro. ADDRESS 201 Fulton Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55620

CERTIFICATE OF DEATH.

64 D 55620

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 N. 36th St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H. Goodrich

(a) RESIDENCE. No. 1114 N. 36th St. 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adelbert Goodrich

6 DATE OF BIRTH (month, day, and year): Aug. 29-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of Industry, business, or establishment in which employed (or employer): None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Maryland

PARENTS

10 NAME OF FATHER: John H. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Susan J. Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Frank T. Goodrich 1114 N. 36th St.

15 Filed JUL 26 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year): July 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1921, to July 22 1921, that I last saw her alive on July 22-21, and that death occurred, on the date stated above, at 1.35 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma &
Myocardial insufficiency
Contributory (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral hemorrhage
(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) W. H. Smith, M. D.

, 19 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	July 26 1921

20 UNDERTAKER: Horace H. Burgee ADDRESS: 363 Falls Rd.

CAUSE OF DEATH in plain terms. No abbreviations or terms of uncertain meaning may be used. Any exceptional delay in registration of certificates. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55621

HEALTH DEPARTMENT—CITY OF BALTIMORE

8.091 D 55621

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 3526 Cedar Ave. ST.: 13 WARD)

2-FULL NAME Donald Paul Gagg

(a) RESIDENCE. NO. 3526 Cedar Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 19-1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Frayette Co. La.
(State or country)

PARENTS

10 NAME OF FATHER Robert M. Gagg

11 BIRTHPLACE OF FATHER (city or town) Richmonster
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary K. Hampshire

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co.
(State or country) Md.

14 Informant Robert M. Gagg
(Address) 3526 Cedar Ave

15 JUL 26 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from March 29 1921, to July 23, 1921, that I last saw him alive on July 22 1921, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis & Broncho Pneumonia

3 mo (duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. Smith M. D.

. 19 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL July 26 1921

20 UNDERTAKER Horace H. Burgee — ADDRESS 363 Walbrook Ave

CAUSE OF DEATH in plain terms. If that of a disease state whether from Violent Cause. Suicidal, or Homicidal. Write plainly. Spelling is important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

55622

CERTIFICATE OF DEATH. 79 D 55622

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 610 S. Eutaw ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Mason

(a) RESIDENCE. NO. 610 S Eutaw ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Mason Emburson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 870

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greenwood Va

PARENTS

10 NAME OF FATHER Anthony Sykes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Pinkey Harris (Address) 610 S Eutaw st

15 JUL 26 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1921, to July 24, 1921, that I last saw her alive on July 24, 1921, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows: Cardiac Arrest Valvular

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Asthenia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation & symptoms

(Signed) C. F. Hoffman M. D.

, 19 (Address) 712 S Paca Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	July 26 1921

20 UNDERTAKER C. W. Brown & Son ADDRESS 701 N. Monroe St.

CAUSE OF DEATH in plain terms, so that it may be classified. Do not use abbreviations or symptoms. Be sure that the PLACE OF OCCURRENCE is given. See back of certificates. INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

149279 D 55623

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55623

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carmello Anogunni

(a) RESIDENCE NO. 374 N. Exeter St. Balto Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of Marie

6 DATE OF BIRTH (month, day, and year) Nov. 29-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Vito Anogunni

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Concetta Ladussa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Johns Hopkins Hospital Record.

15 Filed JUL 26 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5 1921 to July 24 1921, that I last saw h alive on July 24 1921, and that death occurred, on the date stated above, at 12 03 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Abscess Brachial Tuberculous (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 7, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George M. Ryon M. D.

7-25-21 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent - Cemetery

DATE OF BURIAL 7/26/21

20 UNDERTAKER H E Hughes. ADDRESS 4nr N Broadway

CAUSE OF DEATH in plain terms, so that a TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(See affadavit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55624

CERTIFICATE OF DEATH.

D 55624

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2413 Brookfield Ave ST.; 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Harris

(a) RESIDENCE. NO. 2413 Brookfield Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., If of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Harris

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1411 E Baltimore St

15 Filed JUL 26 1921, 19 ROBERT J. KRAUTER Registrar

Burial Permit Given

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1921, to July 24, 1921, that I last saw her alive on July 24, 1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma urethra bladder & vaginal walls (operation 4 months)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Pt Rankin - Starvation

gradual (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? 1725 S. Bait St

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Typical Microscopic

(Signed) Frank G. Smith, M. D.

, 19 (Address) 927 S. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	7/26 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Baltimore St

On this 22nd day of September, 1921 before me a Notary Pu
of the City of Baltimore, State of Maryland personally appeared Jack
and made oath in due form of law that the age given on the Death Cert
of Sarah Harris as sixty two (62) years is incorrect and that the corr
age is fifty eight (58) years.

Jack Lewis

Mrs. Bogat

Notary Public 1411 E. Balto. St.

Seal

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55625

CERTIFICATE OF DEATH.

113 D 55625

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Rosen

(a) RESIDENCE. No. 111 Granby ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Katie Rosen.

6 DATE OF BIRTH (month, day, and year) Oct 1, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 640

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isreal Rosen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Suragi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lewis (Address) 1411 E Baltimore

15 Filed JUL 25 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1921, to July 25, 1921.

That I last saw him alive on July 25, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea & Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis & Pneumonia

& Lungs (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Logic & Symptoms

(Signed) John J. Erwin, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run — DATE OF BURIAL: July 26 1921

20 UNDERTAKER: Jack Leidis — ADDRESS: 1411 E Balto

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55626

37-091

D 55626

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Asylum ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Graul

(a) RESIDENCE. No. Bay View Asylum ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. Unknown mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ? Unknown

7 AGE: Years 62; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS

10 NAME OF FATHER: ? Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Unknown

14 Informant: Annie Larsen (Address) 1477 W Gay

15 JUL 26 1921 19 ROBERT J. KRAUTER Registrar

CAUSE OF DEATH in plain terms. Do not use abbreviations or technical terms. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21. 1921. to July 22. 1921. that I last saw her alive on July 22. 1921. and that death occurred, on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane.

OVR

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Broncho-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? none

What test confirmed diagnosis? by clinical findings

(Signed) H. E. Adkins, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Back Cemetery

DATE OF BURIAL: July 27 1921

20 UNDERTAKER: Pitt Johnson

ADDRESS 11x24 Pm

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to
Lues.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55627

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 55627

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 N Curley ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Spencer

(Residence in Baltimore: No. 515 N Curley St.; — yrs. 9 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 5 (Day), 1920 (Year)

7-AGE, — yrs. 9 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, James A. Spencer

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Julia Stadtlander

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Julia Spencer

(Address) 515 N. Curley St.

15-

Filed JUL 26 1921, 191.....

ROBERT P. KRAUTER
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 22 1921, to July 25 1921, that I saw h— alive on July 25 1921, and that death occurred, on the date stated above, at 12 1945 m.

The CAUSE OF DEATH* was as follows:

Acute - Ileo - Colitis

(Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) John G. Clemens M. D.

July 25, 1921 (Address) 1 East Pleasant St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, 1st German — DATE OF BURIAL, July 26, 1921

20-UNDERTAKER Peter Nicolaus — ADDRESS 2046 Eastern

CAUSE OF DEATH to be plainly written. Every question important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55628

CERTIFICATE OF DEATH.

8-D 55628

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hospital ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Mathias

(a) RESIDENCE. No. Nursery & Childs Hosp ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1919

7 AGE 2 Years 5 Months 23 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Philadelphia, Pa.

PARENTS

10 NAME OF FATHER Louis C. Mathias

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md

12 MAIDEN NAME OF MOTHER Alice McAfee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md

14 Informant Olin W. Mathias

(Address) 1634 John Street

15 Filed JUL 26 1921 ROBERT J. KRAUSE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20 1921 to July 25 1921 that I last saw him alive on July 25 1921 and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Whooping cough.

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of ——

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Emil Steinglass, M. D.

19 (Address) 2009 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: July 27 1921

20 UNDERTAKER: Wellman Co. — ADDRESS: 502 E. North

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

alvina

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55629

CERTIFICATE OF DEATH.

25-156 D 55629

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 8 St. Morrell Pk. St.; 25 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Galvina Wurzberger

(Residence in Baltimore: No. 8 St & Morrell Pk St. (yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, July 11, 1846
(Month) (Day) (Year)

7-AGE, 35 yrs. 7 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework 031
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Bernhardt Trogen

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Wurzberger

(Address) 8th St Morrell Pk

15-

Filed JUL 26 1921 191... ROBERT I. KRAUTH Registrar.

Burial Permit [illegible]

N. B.—Every item of information called for in CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas Suicide while temporarily insane

Hours (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jones M Fenton M. D.
(Coroner.)

July 25, 1921 (Address) 700 E Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	July 27, 1921
20-UNDERTAKER Wallace Coff	ADDRESS 502 E Monk Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55630 D 55630

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 170

CITY OF BALTIMORE (No. Mercy Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Burrow

(Residence in Baltimore: No. 1723 Brust st — St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colrd	Single

6-DATE OF BIRTH, Sept (Month) 8 (Day), 1914 (Year)

7-AGE,	If LESS than 1 day,
6 yrs. 10 mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: born
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Major Burrow

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Maude Gaines

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Major Burrow

(Address) 1723 Brust st

15- Filed JUL 26 1921, 191... ROBERT J. CRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ~~Coroner, autopsy~~ or inquiry.) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in right side of abdomen causing Hemorrhage

(Duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary) accidentally shot by son

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. K. Gorsuch M. D.
(Coroner.)

7.25., 192. (Address) 117 N. Gay st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	July 26 1921

20-UNDERTAKER	ADDRESS
Edward Ringgold	1463 N Pine

N. B.—Every CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92-061X

92-D 55631

CERTIFICATE OF DEATH.

D 55631

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infirmary ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Geo. Adreon

(a) RESIDENCE. NO. 918 Burgundy ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 5 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	6	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Orderly 086
(b) General nature of Industry, business, or establishment in which employed (or employer) Church Home
(c) Name of employer & Infirmary Balto Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Adreon
11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md
12 MAIDEN NAME OF MOTHER Ella J. Holland
13 BIRTHPLACE OF MOTHER (city or town) Talbot Co (State or country) Md

14 Informant Laura V. Simone
(Address) 918 Burgundy St

15 Filed JUL 26 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5. 1921, to July 25. 1921, that I last saw h.. alive on July 25 1921, and that death occurred, on the date stated above, at 2:45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Emphysema
C.S. Meningitis (duration) yrs. 2 mos. 20 ds.

CONTRIBUTORY (Secondary) meningitis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory

(Signed) H. H. Ganff M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Gar. Co.	July 27 1921

20 UNDERTAKER JOHN F. DENNY ADDRESS 715 LIGHT ST.

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55632

CERTIFICATE OF DEATH.

120 D 55632

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N. Milton ave ST.; 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. Walter

(a) RESIDENCE. No. 103 N. Milton ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George H. C. Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jennie Walter
(Address) 103 N. Milton ave

15 JUL 26 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1921 to July 23, 1921, that I last saw h[illegible] alive on July 23, 1921 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Anaemia Secondary

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock M. D.

. 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bivalve Wyconico Co. Md	July 27 1921
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be [illegible] of certificates. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 55633

REGISTERED NO.

D 55633

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Ensor St. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Baby~~ (Baby) Hawthorne.

(a) RESIDENCE. NO. 714 Ensor St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	—

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 18, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 8 hrs. or 40 min.
✓	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. 663

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Arthur Hawthorne.

11 BIRTHPLACE OF FATHER (city or town) S. C.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Timmons

13 BIRTHPLACE OF MOTHER (city or town) S. C.

(State or country)

14 Informant J. O. L'asendale.

(Address)

15 Filed JUL 26 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1921, to July 18, 1921, that I last saw him alive on July 18, 1921, and that death occurred, on the date stated above, at 4:50 P m.

The CAUSE OF DEATH* was as follows:

Prematurity 7 mos.

(duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) ✓ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) E. L. Stow, M. D.

7/23 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUL 25 19

CAUSE OF DEATH. See instructions on back of certificate. ATION is very important.

JOHNS HOPKINS HOSPITAL
Commissioner Health.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55634

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55634

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1233 David Hillaire St.; 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Heath

(Residence in Baltimore: No. 1233 D. Hillaire St.; 42 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	Col	Mar.

6-DATE OF BIRTH, 7 (Month) (Day) 1842 (Year)

7-AGE, 79 yrs. mos. da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoe-maker
(b) General nature of industry, business, or establishment in which employed (or employer): 088

9-BIRTHPLACE, (State or Country). Kent Island

PARENTS.

10-NAME OF FATHER, Jacob Heath

11-BIRTHPLACE OF FATHER (State or Country), ? Md

12-MAIDEN NAME OF MOTHER Hannah Wright

13-BIRTHPLACE OF MOTHER (State or Country), ? Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Benjamin Heath

(Address) 520 W. Cross St

15- Filed JUL 26 1921 191 ROBERT I KRAUTER Registrar.

CAUSE OF DEATH must be filled in. It is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 (Month) 24 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Feb 14 1921, to July 24 1921, that I saw h[illegible] alive on 191, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) yrs. 7 mos. da.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. da.

(Signed) F. McCauley M. D.

7-25-, 1921. (Address) 1524 D Hillaire

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	7-26-, 1921

20-UNDERTAKER	ADDRESS
Sam'l H Chase & Son	400 Mosher

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55635

CERTIFICATE OF DEATH.

120 D 55635

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 2616 Fleet ST.: 1 WARD)

2-FULL NAME Josephine A Price

(a) RESIDENCE. NO. 2616 Fleet ST.. 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Adolph. Price

6 DATE OF BIRTH (month, day, and year) May 17 - 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (037)

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Ernst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant For Adolph Price. M J. Sadowski.

(Address) 2616 Fleet St

15 Filed JUL 26 1921 BOYER & BRAUER Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17 I HEREBY CERTIFY, That I attended deceased from May 12 1921 to July 24 1921.

that I last saw him alive on July 24 1921.

and that death occurred, on the date stated above, at 9.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Tubal Nephritis

(duration) 9 yrs. 2 mos. 12 ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically. &

(Signed) C. L. Long, M. D.

7-25-1921 (Address) 2701 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: July 27 1921.

20 UNDERTAKER: M J. Sadowski — ADDRESS: 905 S. Ann St

mation should be given in answering the following questions. Use ditto marks only when they will convey the information required. Do not use them for the CAUSE OF DEATH in plain terms, so that it may be understood by the general reader. The NATURE OF OCCUPATION is very important. See instructions on back of certificates.

D 55636

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 D 55636

REGISTERED NO. C .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 1a.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No Cecil Apt. 3D ST. 11 WARD)

2 FULL NAME John Wilson Brown. Sr. (Residence in Baltimore: No. Cecil Apartments St. Paul & Eutaw Sts. Mount Vernon Place)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White Amer

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: July 30th (Month) (Day), 11836 (Year)

7 AGE: 84 yrs. 11 mos. 25 ds. (If LESS than 1 day, ... hrs. or ... min.?)

8 OCCUPATION (a) Trade, profession, or particular kind of work: Clergyman P.E. Official (b) General nature of industry, business, or establishment in which employed (or employer): 613

9 BIRTHPLACE (State or country): Balt. City

PARENTS

10 NAME OF FATHER: J. Harman Brown

11 BIRTHPLACE OF FATHER (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Margaretta Wilson

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Walter S. Ufford

(Address) 404 Argyle Apt-DE

15. FILED JUL 26 1921 ROBERT I. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 25th (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20th, 1921, to July 25th 1921, that I saw h[illegible] alive on July 25th, 1921, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 5 yrs. mos. ds.

Contributory (SECONDARY) Excitement of Thoughts

(Duration) yrs. 1 mos. ds.

(Signed). Thomas L. Shearer M. D.

, 191 (Address) 905 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: July 27 1921

20 UNDERTAKER: John B. Spence ADDRESS 1320 N. Caroline St.

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55637 ✓

D 55637

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Aged Mens Home (ST.) 19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm E Tucker

(a) RESIDENCE. No. 1400 W Lexington ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24/1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Wm Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D.C.

12 MAIDEN NAME OF MOTHER Elizabeth Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash D.C.

14 Informant Mrs H. M. Tiedeman (Address) Matron.

JUL 26 1921

ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1924, to July 26, 1921,

that I last saw h alive on July 20 1924.

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

July 26/1921 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL July 28 1924

20 UNDERTAKER George J. Smith

ADDRESS 1000 W Fayette St

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55638

CERTIFICATE OF DEATH.

37 D 55638

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Vincents Infant Asylum

CITY OF BALTIMORE: (NO. 1401 Division St. ST.: 14 WARD)

2-FULL NAME Vincent Hartman

(a) RESIDENCE NO. 1401 Division St. ST. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 7, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Peter Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Kathryn Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Sr. Vincent de Paul
(Address) 1401 Division St

15 Filed JUL 26 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 . 19 21 . to July 25 . 19 21.
that I last saw him alive on July 25 . 19 21.
and that death occurred, on the date stated above, at 11 a. m.
The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Clendinen M. D.

July 26, 19 21 (Address) 154 W Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL July 26, 1921

20 UNDERTAKER Wm. Fiallowski & Sons

ADDRESS 1618 Eastern Ave

mation should be carefully answered, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 55639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159

D 55639

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2019 Eutaw Place ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter L. Bixby

(Residence in Baltimore: No. 2019 Eutaw Place. St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Dec., 1st., 1857 (Month) (Day) (Year)

7-AGE. 63 yrs. 7 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Lead Burner 086
(b) General nature of industry, business, or establishment in which employed (or employer). Metal Business.

9-BIRTHPLACE, (State or Country), Boston, Mass

PARENTS.

10-NAME OF FATHER. Moses Bixby

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta M. Bixby

(Address) 2019 Eutaw Place.

15- Filed JUL 26 1921 191.. Burial Permit Issued ROBERT P. KRAUTER Registrar.

N. B. Every item in CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) jury find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shot by revolver
wound in head
(Duration) yrs. mos. ds. Instant death

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Kennedy M. D. (Coroner)

July 25. 191.. (Address) 3802 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, 7/27 19.21

20-UNDERTAKER C. F. Evans & Son

ADDRESS 115 W. Mt Royal Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55640 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55640

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE, No. St. Agnes Hosp. ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ardie A. Peal

(a) RESIDENCE. No..... Severn Md ST., WARD. Severn Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1855

7 AGE: Years 66 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Do Not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do Not Know

14 Informant (Address): Mrs. Jennie Foulows Severn Md

15 Filed JUL 26 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-25 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-9 1921, to 7-25 1921, that I last saw h[illegible] alive on 7-25 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Intussusception (Caecum into R-colon).

(duration) — yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary) Incontinence (fecal fistula) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 7-14-21

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Dudley P Bowen M. D.

. 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cemetery Frederick Co

DATE OF BURIAL: July 27 1921

20 UNDERTAKER: [illegible] S. N. FINK

FUNERAL DIRECTORS

[illegible] W. PRATT STREET

ADDRESS

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. Do not use abbreviations or technical terms. Be sure to answer all questions. Every statement must be full and complete. Do not omit any information because you may think it unimportant. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55641

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55641

43

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 N. Central Ave. 9th WARD)

2-FULL NAME. Richard D. Pittinger

(a) RESIDENCE. NO. 1408 N. Central Ave ST., 9th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Mary E. Pittinger

6 DATE OF BIRTH (month, day, and year) Jan 26th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) City Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard Pittinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant (Address) John J. Pittinger 2916 E. Pratt St.

15 Filed 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1921, to July 25, 1921, that I last saw him alive on July 24, 1921, and that death occurred, on the date stated above, at 5.20 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Neck

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? yes Date of April

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Alys Gage, M. D.

, 19 (Address) 1906 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 28th 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 400 S. Howard

CAUSE OF DEATH must be plainly stated. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 55642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55642

CERTIFICATE OF DEATH.

8-091

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1104 Gilmor ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ray Lewis Hammond

(a) RESIDENCE NO. 1110 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 15 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Geo A Hammond

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Lucia Lomax

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Geo A Hammond
(Address) 1104 Gilmor St.

15 Filed Robert P. Harrison, 19
Registrar
Burial Permit Clerk

2 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 19 21

17

I HEREBY CERTIFY, That I attended deceased from July 21, 19 21, to July 25, 19 21, that I last saw h alive on July 24, 19 21, and that death occurred, on the date stated above, at 2 20 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos ? ds.

CONTRIBUTORY (Secondary) Whooping-cough ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry H. Weinberger, M. D.

July 25, 19 21 (Address) 724 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL July 27 1921

20 UNDERTAKER Clarence E Wright — ADDRESS 66 W Cary

CAUSE OF DEATH in plain terms, so that it may be classified. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55643 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55643

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Riley

(a) RESIDENCE. No. 642 W. Fayette St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Riley

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Riley

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Hospital Records,
(Address) New City Hospital

15 Filed JUL 26 1921, 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 18, 19 21, to July 21, 19 21, that I last saw him alive on July 20, 19 21, and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver (primary in bile ducts)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 2 yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None No.

What test confirmed diagnosis?

(Signed) Clyde Mc Neil, M. D.

7/21/21 19 Address New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	JUL 26 1921 19
20 UNDERTAKER Commissioner Health.	ADDRESS

CAUSE OF DEATH in plain terms, so that a layman may understand it. Name of disease alone is not sufficient. Do not use abbreviations. TION is very important. See instructions on back of certificates.

✓ 158 D 55644

D 55644 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. Druid Hill Park

REGISTERED No. C

1 PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 1st Royal Regiment St. 12 WARD)

2 FULL NAME Walter Osten

(Residence in Baltimore: No. 2422 Buchanan St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Single

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE About 30 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Sailor 040
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Frazer

(Address) 2422 Buchanan

15- Filed ....., 191.....
Registrar.

Robert P. Harrison, Burial Permit Clerk

JUL 26 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

July 20, 1921 (Address) 3632 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, ...

DATE OF BURIAL, JUL 26 1921, 19....

20-UNDERTAKER .....

ADDRESS .....

UNIVERSITY OF MARYLAND

Commissioner Health.

Per Wm. E. WOODALL

Every CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55645

D 55645

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 S. Norris St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Guy

(a) RESIDENCE. NO. 308 S. Norris St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Guy

6 DATE OF BIRTH (month, day, and year) Aug. 10" 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery County Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "Unknown Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles W. Guy
(Address) 308 S. Norris St.

15 Filed JUL 26 1921 19 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25" 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to July 25, 1921.
that I last saw him alive on July 20, 1921.
and that death occurred, on the date stated above, at 2.10 P. m.
The CAUSE OF DEATH* was as follows:

Endocarditis
Valvular Insufficiency

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jas. E. Mrse M. D.

July 26 1921 (Address) 1520 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral.	July 27 1921
20 UNDERTAKER	ADDRESS
Joseph L. B. Cook.	1003 N. Balto St

mation should be given in these answers as will enable the Undertaker to make a complete return. Use only letters and figures and make all statements in ink. Do not use ditto marks. CAUSE OF DEATH in plain terms, so that it may be properly classified. Statements of "Old Age," "Senility," "Natural Causes," "Unknown," etc., are not sufficient. OCCUPATION is very important. See instructions on back of certificates.

D 55646 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55646

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 315 S Bruce St ST.: 19 WARD) REGISTERED No. C 170.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret Goodwin

(Residence in Baltimore: No. 315 S Bruce St.; yrs., 38 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1 (Year)

7-AGE, 63 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Michael Regan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Bridget O'Rourke

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Goodwin

(Address) 315 S Bruce St

15-

Filed ....., 191.... Robert P. Harrison,

Registrar.

JUL 26 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Indefinite yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) James M. Fenton M. D. (Coroner.)

July 26 1921 (Address) 710 E. Clarks

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Cathedral Cem.	July 29, 1921
20-UNDERTAKER Jos. O. Cook	ADDRESS 1002 W. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55647

D 55647

CERTIFICATE OF DEATH.

REGISTERED NO. 5 - 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sewell

(a) RESIDENCE. NO. 413 Mott St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(of) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 17 - 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. 021

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer Inmate in Balt-3174

9 BIRTHPLACE (city or town) (State or country) Kent Island Maryland

PARENTS

10 NAME OF FATHER James Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant, (Address) Josephine Williams 1114 S. Stockton

15 Filed JUL 26 1921 : 19 Robert [illegible] Registrar

Burial Permit Cr[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17

I HEREBY CERTIFY, That I attended deceased from July 23, 1921, to July 25 1921.

that I last saw her alive on July 25, 1921.

and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Appendiceal abscess

Surgical shock (duration) yrs. mos. 1 ds.

Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 24 1921

Was there an autopsy? No

What test confirmed diagnosis? Surgery

(Signed) John J. Ellison, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kent Island md	July 27 21

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1735 Ashland Av

IMPORTANT. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55648 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55648

CERTIFICATE OF DEATH. REGISTERED NO. C 1879

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Southern Hospital St.; 18 WARD)

2-FULL NAME John W. S. Slanker (If St.; 73 yrs., mos. ds.)

(Residence in Baltimore: No. 411 N. Schroeder St.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, August (Month) 19 (Day), 1847 (Year)

7-AGE, 73 yrs. 11 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Farmer (b) General nature of industry, business, or establishment in which employed (or employer) Farm

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Edward Slanker

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth Kemp

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnetta E. Slanker

(Address) 411 N. Schroeder St

15- Robert P. Harrison,

Filed ....., 191..... Registrar.

DL 261921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1921, to July 25 1921, that I saw h him alive on July 25 1921, and that death occurred, on the date stated above, at 1.40 p.m.

The CAUSE OF DEATH* was as follows: (Initial Organic heart disease Chronic)

(Duration) ..... yrs. ..... mos. 46 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Slaughter M. D.

July, 1921 (Address) 1027 Cold Spring Lane

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL ~~OR REMOVAL~~ Loudon Park — DATE OF BURIAL, July 28, 1921.

20-UNDERTAKER Geo W. Little — ADDRESS 2706 Edmondson Av

Cross out words not important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 55649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55649

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 762 Bartlett ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George. E. Brice

(a) RESIDENCE NO. 762 Bartlett ST. WARD Rock Hall Md

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 If married, widowed, or divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 1919

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
1	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rock Hall Md

PARENTS

10 NAME OF FATHER Geo. E. Brice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rock Hall Md

12 MAIDEN NAME OF MOTHER Margaret Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George E. Brice
(Address) Rock Hall

15 Filed 7 26 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to July 26, 1921.

That I last saw him alive on July 26, 1921, 9 PM m

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation.

Pulmonary Oedema (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Laryngeal Diphtheria (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 7-25-21

Was there an autopsy? No

What test confirmed diagnosis? Culture Positive

(Signed) J. J. Corbett, M. D.

, 19 (Address) H. 451 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Hall Md DATE OF BURIAL July 28 1921

20 UNDERTAKER Williams Co/6 ADDRESS Rock Hall Md

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 79

D 55650

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View WARD)

2-FULL NAME. Lizzie Johnson

(a) RESIDENCE. NO. 1703 N. Dallas St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed JL 26 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1921, to July 25, 1921, that I last saw her alive on July 24, 1921, and that death occurred, on the date stated above, at 2:15 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde M. Reed, M. D.

7/25/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	7/28/21

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Hanford Ave

CAUSE OF DEATH in plain words. Do not use abbreviations or technical terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55651

D 55651

CERTIFICATE OF DEATH.

112

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013. Fawn St ST.; 3 WARD)

2-FULL NAME Mary Edmonell

(a) RESIDENCE NO. 1013 Fawn St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs mos ds. How long in U. S., if of foreign birth? 50 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or ~~divorced~~ (or) WIFE of: John. Edmonell

6 DATE OF BIRTH (month, day, and year): Unknown 1857

7 AGE: Years 64. Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England.

PARENTS

10 NAME OF FATHER: John. Duffy.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Jos Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Nellie Cleiver

(Address): 1013 Fawn St

15 Filed JUL 26 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1921, to July 25, 1921, that I last saw h~~e~~r alive on July 24, 1921, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus (Body)

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion (duration) yrs. mos. 2 ds

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. L. Callaston M. D.

July 26 1921 (Address) 1038 W Mtn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: July 27 1921

20 UNDERTAKER: Wendell Leppel & Son

ADDRESS: Baltimore

CAUSE OF DEATH in plain terms. State whether from Violent Cause. See back of certificates. TION is very important. See instructions on back

D 55652 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55652

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Josephs Hospital ST. 11 WARD)

REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Frederick Stevenson

(Residence in Baltimore: No. 15 E Eager St.; yrs. 59 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1861
(Month) (Day) (Year)

7-AGE, 59 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Driver
(b) General nature of industry, business, or establishment in which employed (or employer)..... 023

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George Stevenson

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Sarah Luther

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Rife

(Address) Rife Building (Fallsway)

15- Robert P. Harrison,

Filed....., 191.....
Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

L 261921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Appendicitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... Duration ..... yrs. ..... mos. ..... ds.

(Signed) Kirk Smiley M. D.
(Coroner)

7-27-, 1921. (Address) 4 E Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	July 27, 1921
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55653

CERTIFICATE OF DEATH.

170 D 55653

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 N. Hoffman ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Neal Watkins

(a) RESIDENCE. NO. 315 N. Hoffman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

037

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Chas Tockett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs Edw Tockett 315 N. Hoffman st

15 Filed JUL 27 1921, 19 ROBERT F. KNAUER Registrar

Burial ... Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17

I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to July 26, 1921, that I last saw h[illegible] alive on July 26, 1921, and that death occurred, on the date stated above, at 9:10 a. m.

The CAUSE OF DEATH* was as follows:

Bright disease

(duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) asteria sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Wheatley, M. D.

7/26 1921 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt O Auburn Cem	July 28 1921

20 UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic nephritis.
No hemorrhage.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 55654 — REGISTERED No. C 104 D 55654

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1150 Cookin ST.: 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Majewski

(Residence in Baltimore: No. 1150 Cookin Dr St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH May 14, 1921 (Month) (Day) (Year)

7 AGE ..... yrs. 2 mos. 12 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Majewski

11 BIRTHPLACE OF FATHER (State or country) Poland

12 MAIDEN NAME OF MOTHER Kate Garbutch

13 BIRTHPLACE OF MOTHER (State or country) Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos. Majewski

(Address) 1150 Cookin

15 [illegible] ROBERT J. [illegible] REGISTRAR

Filed JUL 27 191 JUL 27 1921 JUL 2 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 26, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1921, to July 26 1921, that I saw him alive on July 25, 1921, and that death occurred, on the date stated above, at 12.01 a m.

The CAUSE OF DEATH* was as follows:

Mis Carditis

(Duration) ..... yrs. ..... mos. 5 ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos F. Stevens M. D.

July 26, 1921 (Address) 2866 Lamport Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Holy Cross Cem. — DATE OF BURIAL July 27 1921

20 UNDERTAKER Jacob Fallkowski — ADDRESS 425 S. Conkling

N. B.—Every item of information should be carefully supplied. Exact statement of facts must be given, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of facts must be given, so that it may be properly classified. Exact statement of facts must be given, so that it may be properly classified. Exact statement of facts must be given

Spec.—1-10-21—M&T—1500 Bks.

149363 D 55655

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

104 D 55655

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 6 WARD)

2-FULL NAME Samuel Carter.

(a) RESIDENCE NO. 1509 E Fayette St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced, ~~HUSBAND of~~ ~~or) WIFE of~~ William + Mary Carter

6 DATE OF BIRTH (month, day, and year) Sept 20 1920

7 AGE: Years — Months 9 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) born in Balto.

PARENTS

10 NAME OF FATHER William Carter

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Va ?

12 MAIDEN NAME OF MOTHER Mary James

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) born in Va

14 Informant (Address) Johns Hopkins Hospital Record

15 Filed JUL 27 1921 ROBERT J KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8 1921 to July 26 1921 that I last saw him alive on July 26 1921 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) 6 yrs. 6 mos 21 ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? ~~No~~ yes

What test confirmed diagnosis?

(Signed) George M. Lyon, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL July 27 1921

20 UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that no other cause can be substituted. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55656

CERTIFICATE OF DEATH.

D 55656

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 W. Preston ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Reynolds

(a) RESIDENCE. NO. 318 W. Preston ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Charles Reynolds (Address) 318 W Preston St

15 Filed JUL 27 1921, 19 ROBERT J KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to July 25, 1921, that I last saw him alive on July 25, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Died about an hour after I saw

the case (duration) yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) No other history can be obtained (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Bellacasa, M. D.

, 19 (Address) 829 Hamilton Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 27 1921
20 UNDERTAKER	ADDRESS 1140 W.
Brown & Freeland	Baltimore St

CAUSE OF DEATH in plain terms, so that it may be of certificates. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55657

CERTIFICATE OF DEATH.

47 D 55657

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anita Jenkins

(a) RESIDENCE. No. 1103 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54y yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. C. Jenkins

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John Scotton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Ellen Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed JUL 27 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1921, to July 23, 1921, that I last saw h er alive on July 23, 1921, and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Carcinoma

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Clyde O'Neill, M. D.

7/23/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Laurel Lawn	July 27, 1921
20 UNDERTAKER	ADDRESS
Samuel Kennedy	Mt. Ida

Spec.—6-9-19—R. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55658

CERTIFICATE OF DEATH.

15-9 D 55658

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Stockton ST.: 15 WARD)

2-FULL NAME Dora Harvey

(a) RESIDENCE. NO. 1303 Stockton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Harvey

6 DATE OF BIRTH (month, day, and year) July 25 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 007

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Buck Brogden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas. Harvey

(Address) 1303 Stockton St.

15 Filed JUL 27 1921 19 ROBERT J. COOK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to July 24, 1921, that I last saw h[illegible] alive on July 24, 1921, and that death occurred, on the date stated above, at 8-20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Green M. D.

7-25 1921 (Address) 120½ Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	July 27 19 21
20 UNDERTAKER James H. Daniels	ADDRESS 303 Presstman St

CAUSE OF DEATH to be filled in by physician. See instructions on back of certificate. TION is very important.

Buried from Chapel

D 55659 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

156 D 55659

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(PLACE OF DEATH

CITY OF BALTIMORE (No. 2209 Wilkens ave ST. 20 WARD)

2-FULL NAME John Wesley Jones

(Residence in Baltimore: No. 2209 Wilkens ave

St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, Oct (Month) 6 (Day), 1872 (Year)

7-AGE,	If LESS than 1 day,
48 yrs. 9 mos. 19 ds.	....hrs. or 031 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): Penn. R.R.

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Alexander Jones

11-BIRTHPLACE OF FATHER (State or Country), Elkhorn City Ky

12-MAIDEN NAME OF MOTHER Abbey Ball

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. Henry Rigby

(Address) 2209 Wilkens ave

15-

Filed ..... 191.....

JUL 27 1921

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poisoned by Poisoning Strychnine

Asphyxiation by Illuminating Gas Self Inflicted

(Duration) Accident yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James Milton M. D.
(Coroner.)

July 26, 1921 (Address) 700 Cleveland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, July 28, 1921

20-UNDERTAKER Jos B Cook

ADDRESS 1003 N Balto St

N.B.—Every answer must be full and complete. CAUSE OF DEATH in plain terms, so that it may be properly classified. Omissions will delay burial. Be particular and exact in answering all questions, as every item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 55660

REGISTERED NO.

D 55660

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 Augusta Ave, ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary A. Bellerman.

(a) RESIDENCE. NO. 130 Augusta Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. E. Bellerman

6 DATE OF BIRTH (month, day, and year) Oct 20 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70 yrs	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Mary Cadle

(Address) 130 Augusta Ave

15 Filed JUL 27 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

CAUSE OF DEATH in plain words. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to July 26, 1921.

that I last saw her alive on July 26, 1921.

and that death occurred, on the date stated above, at 8 25 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage.

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary edema.

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? clinical

(Signed) Dudley P. Bowe. M. D.

19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: July 29 1921

20 UNDERTAKER: Joseph L. B. Cook ADDRESS: 1103 N. Gay St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55661

D 55661

CERTIFICATE OF DEATH.

79-091

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary Silberman

(Residence in Baltimore: No. 515 S. Sharp St St.: 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	married

6-DATE OF BIRTH, [illegible] (Month) (Day) 1883 (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Israel Israelson

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laws

(Address) 1411 E Baltst

15- FILED JUL 27 1921 1921 [illegible]

CAUSE OF DEATH must be stated in every case. See instructions on back of certificate. Items 16 to 20 are important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 21, 1921 to July 26 1921, that I saw h[illegible] alive on July 26, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Chronic Myocardial Insufficiency

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Albert Jaffe M. D.

July 26, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. 1 mos. 2 ds. In the State 10 yrs. mos. ds.

Where was disease contracted if not at place of death? at Home

Former or usual residence 515 S Sharp St

19-PLACE OF BURIAL OR REMOVAL. Hebrew Mash Rord — DATE OF BURIAL. July 27 1921

20-UNDERTAKER Jack Laws — ADDRESS 1411 E Balt St

Cornell.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55662

CERTIFICATE OF DEATH.

17 H 7

REGISTERED NO. D 55662

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View) (WARD) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Jones Cornell

(a) RESIDENCE. No. 549 Oxford St. ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1898

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Harry Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Evans

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

13 Informant: Hospital Records, New City Hospital.
(Address)

15 Filed JUL 27 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 16, 1921, to July 25, 1921, that I last saw h alive on July 24, 1921, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Secondary Anemia

(duration) yrs. 8. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. Neill, M. D.

7/25/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 27 1921
20 UNDERTAKER: John H. Toadvine	ADDRESS 1452 Mt St

CAUSE OF DEATH in plain terms, so that it may be understood by all certificates. TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks

Ralston

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55663 104 D 55663

D 55663

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 E. Belvidere ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeanette Ralston

(Residence in Baltimore: No. 130 E. Belvidere ave St. 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept (Month) 27 (Day), 1920 (Year)

7-AGE, ... yrs. 10 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Child .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Ralston

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Lena Flick

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W. Little

(Address) 2700 Edmondson

15- Filed JUL 27 192, 191.....

ROBERT J. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 26 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1924, to July 26 1924, that I saw her alive on July 26 1924, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Diarrhoea and Enteritis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

7-27, 1924. (Address) ..... George Emerson Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. London Park

DATE OF BURIAL. July 28, 1924.

20-UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

N.B.—Every item must be filled in. CAUSE OF DEATH in plain terms, so that it may be properly classified. All questions important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55664

CERTIFICATE OF DEATH.

X 8172 D 55664

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 2310 Aisquith St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Findlay

(Residence in Baltimore: No. 2038 Hanover St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1878
(Month) (Day) (Year)

7-AGE, 42 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Soldier U.S. Army
(b) General nature of industry, business, or establishment in which employed (or employer): U.S. Army

086

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, John Findlay

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER, don't know

13-BIRTHPLACE OF MOTHER (State or Country), don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Moran

(Address) 300 E Baltimore St.

15- Filed JUL 27 1921 ROBERT F. KRAUSER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism. Fell off steps at 2310 Aisquith

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. F. Knabley (Coroner.)

7-25 1921 (Address) 4 E. Lex.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Baltimore

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
National Cemetery	7-27, 1921
20-UNDERTAKER J. J. Moran	ADDRESS 300 E Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

1488 23 D 55665

HEALTH DEPARTMENT—CITY OF BALTIMORE D 55665

CERTIFICATE OF DEATH. 104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

2-FULL NAME Baby Savage.

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .....min.
		1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Johns Hopkins Hospital
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Isaac Forest

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Beatrice Savage

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital

15 JUL 27 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1921, to July 24, 1921, that I last saw h alive on July 24, 1921, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 1 mos 18 ds.

CONTRIBUTORY (Secondary) Gen-colitis (ulcerative)

(duration) yrs. ? mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Post-mortem exam.

(Signed) James C. Fop, Jr. M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL JUL 27 1921 19

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55666

CERTIFICATE OF DEATH.

13—64 D 55666

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE (No. 1720 N. Appleton ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertie May Sculley

(Residence in Baltimore: No. 1720 N. Appleton St. St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	married

6-DATE OF BIRTH, Dec. 2, 1874
(Month) (Day) (Year)

7-AGE, 46 yrs. 7 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 039

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James J. Riggin

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Martha Vincent

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. N. Sculley

(Address) 1720 N. Appleton St.

15-JUL 27 1921 ROBERT J. KRAUTER

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, aforesaid and that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy, 10 min.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (no cause given)
(Duration) yrs. 6 mos. ds.

(Signed) J. N. Hemming M. D.
(Coroner.)

July 25 1921 (Address) 2802 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Church Hill Md

DATE OF BURIAL, July 27, 1921

20-UNDERTAKER Sidney Dufur

ADDRESS Bertha Ave Govt. Pl. on N. Rd 60

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55667

CERTIFICATE OF DEATH.

50 D 55667

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Greenmount Ave 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Linz

(a) RESIDENCE. No. 920 Greenmount Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline M. Linz

6 DATE OF BIRTH (month, day, and year) Nov 27-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Bertha Linz

(Address) 920 Greenmount Ave

15 JUL 27 1921 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to July 25, 1921, that I last saw h[illegible] alive on July 25, 1921, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. Hammenbach M. D.

(Address) Light St & Warren Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	July 27 1921

20 UNDERTAKER H. C. Wedefeld & Co ADDRESS 914 Greenmount Ave

CAUSE OF DEATH to plainly state, without abbreviation, the disease causing death, or in deaths from violence, the nature of injury. MEDICAL CERTIFICATE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55668 | 115 | D 55668

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1123 Valley ST.: 10 WARD 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hanrahan

(a) RESIDENCE. NO. 1123 Valley ST., WARD. 10

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward W. Hanrahan

6 DATE OF BIRTH (month, day, and year) July 16 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thos Hanlon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Lester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ella Hanrahan

(Address) 1123 Valley St.

Filed JUL 27 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7.26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1921, to July 26, 1921.

that I last saw her alive on July 25, 1921.

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Acute ~~Ed~~ Suppurative Cholecystitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) about 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Hanlon, M. D.

7 27 1921 (Address) 710 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	July 29 1921

20 UNDERTAKER H. C. Wedefeld ADDRESS 914 Gilmor

CAUSE OF DEATH must be stated plainly. See back of certificates. TION is very important. See instructions on back.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55669

CERTIFICATE OF DEATH.

64

D 55669

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 100 n Carey St. ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George L. Hull

(Residence in Baltimore: No. 100 n Carey St. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Married

6-DATE OF BIRTH, Apr 25, 1870 (Month) (Day) (Year)

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Shoe Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jno Hull

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Eliz Meredith

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Hull

(Address) 100 N Carey St

15-

Filed JUL 27 1921 MORRIS I KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm F Kelly M. D. (Coroner.)

7-26, 1921 (Address) 4 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Loraine Cem. DATE OF BURIAL, 7-27, 1921

20-UNDERTAKER John J Daley Sons ADDRESS 1318 Eagle

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55670

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55670

CERTIFICATE OF DEATH.

REGISTERED NO. 1629

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2014 Harlem Av ST.; 16 (WARD)

2-FULL NAME Dorothy Maltbaum

(a) RESIDENCE. NO. 2014 Harlem ST., 16 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Wesley Maltbaum

6 DATE OF BIRTH (month, day, and year) Sept. 28, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
38	1883	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Harford Co.

PARENTS

10 NAME OF FATHER Frank Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anni Felenbut

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry W. Maltbaum
(Address) 2014 Harlem

15 Filed JUL 27 1921 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7. 1921. to July 25. 1921.
that I last saw h alive on July 24. 21.
and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic Regurgitation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Roy D. McCurdy, M. D.

7/24, 19 21 (Address) 401 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: 7/27/ 1921

20 UNDERTAKER: A Rohde & Son — ADDRESS: Edmondson & Arlington

CAUSE OF DEATH in plain terms, [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55671

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55671

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 N. Madeira St.; 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alva (Cooper) Montgomery

(a) RESIDENCE. No. 617 N. Madeira St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Sept 30 1907

7 AGE — Years: 13 — Months: 10 — Days: 26 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 000

(b) General nature of industry, business, or establishment in which employed (or employer): school child

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Edmund Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Alice Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Alice Cooper Montgomery

(Address): 617 N. Madeira St.

15 Filed: JUL 27 1921 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1921, to July 26, 1921, that I last saw h[illegible] alive on July 25, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy from mitral insufficiency

(estimated)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Syncope from dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. V. Wright, M. D.

7/26/1921 (Address) 1014 S Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 29 1921
20 UNDERTAKER: John W Henderson	ADDRESS 1802 E monument

mation desired. Use ink and write plainly. Do not use pencil. Make no erasures. Be sure to answer every question. Where there is no entry to be made, write "none" or "unknown" as the case may be. Do not leave any blanks. Make entries early and complete them before certificate is filed. Physicians are required to report CAUSE OF DEATH in plain terms, so that it may be readily understood by the laity. Use no abbreviations or symbols. Accuracy in this matter is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55672

CERTIFICATE OF DEATH.

D 55672

64

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Etting ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodora Dent

(Residence in Baltimore: No. 1110 Etting St. St.: 20 yrs., ~~4~~ mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, ... July (Month) 4 (Day) 1880 (Year)

7-AGE, 41 yrs. 6 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife 63
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Edwin B. Gray

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Johanna Douglas

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theodore W. Dent

(Address) 1110 Etting Street

15-

Filed JUL 27 1921 191.... ROBERT I KRAUTER Registrar.

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 24th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23d 1921, to July 24 1921, that I saw h[illegible] alive on July 23rd 1921, and that death occurred, on the date stated above, at 7.20 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

One Day

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) ....yrs. ....mos. 5 ds.

(Signed) [illegible] M. D.

July 26, 1921. (Address) 607 N. Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Aquacco, Prince Georges Co.

DATE OF BURIAL, July 26th, 1921

20-UNDERTAKER Jno. M. Johnson

ADDRESS 1234 Etting St.

CROSS OUT important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55673

CERTIFICATE OF DEATH.

REGISTERED NO. 1228

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 North Calvert St. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen T. Martin

(a) RESIDENCE. NO. 1604 North Calvert St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Martin

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel White

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Drost

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.

14 Informant Miss Marie Martin
(Address) 1604 N. Calvert St.

15 Filed . 19 Registrar

JUL 27 1921 Burial Permit Given

CAUSE OF DEATH to be filled in plain terms. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 19

17 I HEREBY CERTIFY, That I attended deceased from —— 19 17, to July 25 19 21.

that I last saw her alive on July 24 19 21, 5.50 a. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of

Was there an autopsy? -

What test confirmed diagnosis? Physical

(Signed) Chas. Kerkeleman, M. D.

7/26/21 (Address) 210 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/28/21 19

20 UNDERTAKER Henry W. Mears & Son ADDRESS 805 N. Calvert

55674

Kose 1920 40

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 408 Evesham Av ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles. F. Stewart

(a) RESIDENCE. No. 408 Evesham Av ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pearl F Stewart

6 DATE OF BIRTH (month, day, and year) Oct 1 - 1880

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buyer of Toys

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city ~~town~~) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah McGann

13 BIRTHPLACE OF MOTHER (city ~~town~~) (State or country) Baltimore Md

14 Informant Pearl F Stewart
(Address) 408 Evesham

15 Filed JUL 27 1921 ROBERT B. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July - 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2. 1921. to July - 26. 1921.

that I last saw him alive on July - 26. 1921.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Septic

over

(duration) yrs. 7 mos. 24 ds.

CONTRIBUTORY (Secondary) Pulmonary Hemmorhage 5 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray. Clinical

(Signed) H. E. Hoen, M. D.

7-27. 1921 (Address) 5600 York Rd Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	July 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W Fayette

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. Indefinite terms, such as "Heart Failure," "Exhaustion," "Old Age," "Infirmities of Age," "Senility," "Natural Causes," "Cancer," "Tumor," "Abscess," "Paralysis," "Convulsions," "Hemorrhage," "Blood Poisoning," "Septicemia," "Pyemia," "Uremia," "Meningitis," "Peritonitis," "Pleurisy," "Pneumonia," "Bronchitis," "Colitis," "Enteritis," "Nephritis," "Cystitis," "Jaundice," "Dropsy," "Debility," "Malnutrition," "Marasmus," "Inanition," "Cachexia," "Asthenia," "Atrophy," "Anemia," "Diarrhea," "Dysentery," "Hepatitis," "Gastritis," "Duodenitis," "Ulceration," "Fever," "Gastric Fever," "Typhoid Fever," "Typhoid Pneumonia," "Typhoid Peritonitis," "Typhoid Septicemia," "Typhoid Hemorrhage," "Typhoid Ulceration," "Typhoid Perforation," "Typhoid Meningitis," "Typhoid Abscess," "Typhoid Pyemia," "Typhoid Uremia," "Typhoid Cystitis," "Typhoid Nephritis," "Typhoid Jaundice," "Typhoid Dropsy," "Typhoid Debility," "Typhoid Malnutrition," "Typhoid Marasmus," "Typhoid Inanition," "Typhoid Cachexia," "Typhoid Asthenia," "Typhoid Atrophy," "Typhoid Anemia," "Typhoid Diarrhea," "Typhoid Dysentery," "Typhoid Hepatitis," "Typhoid Gastritis," "Typhoid Duodenitis," "Typhoid Ulceration

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history.
Not tuberculous.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55675

CERTIFICATE OF DEATH.

64 D 55675

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2428 Woodbrook Ave STREET) (WARD 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lina Millhauser

(a) RESIDENCE. NO. 2428 Woodbrook Ave STREET WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benedict Millhauser

6 DATE OF BIRTH (month, day, and year) June 29 1830

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Hirsh Hasburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Levi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) German

14 Informant Mrs L Katten (Address) 2428 Woodbrook

15 Filed JUL 27 1921 19 ROBERT J. BRAUNE Registrar Burial Permit Clerk

CAUSE OF DEATH: By what disease or accident and primarily cause, if any, resulting in death. This information is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH (month, day, and year) July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1921, to July 25 1921, that I last saw her alive on July 25 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) apoplexy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? clinical

(Signed) J Fred Seitz, M. D.

7/27 1921 (Address) 2040 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Scranton Pa	July 28 1921
20 UNDERTAKER	ADDRESS
Ward & Goodheim	118 N. Gilmor St

Spec.—6-9-18—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55676

D 55676

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1144 Cathon ST.: 16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Freda Brown

(a) RESIDENCE. NO. 1144 Cathon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? yrs. 6 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Howard Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Essie Stansbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Essie Brown (Address) 1144 Cathon St.

15 Filed JUL 27 1921 ROBERT I. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1921, to July 26, 1921, that I last saw her alive on June 25, 1921, and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. H. Wright, M. D.

1921 (Address) 1204 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chester Md	7-29 1921

20 UNDERTAKER Wm. H. Chase & Son — ADDRESS 1400 Mosher

mation should be carefully written in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-13—H. P. Co.—1000 Bks.

D 55677 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55677

CERTIFICATE OF DEATH.

63

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Dilworth

(a) RESIDENCE. NO. Home for Incurables ST., 21 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year): [illegible] 1865

7 AGE: Years 56 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Dilworth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs. G. Heaps Gelfand Ave. 21st Ward

15 Filed 2 7 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from June 6, 19 21, to July 22, 19 21, that I last saw h[illegible] alive on July 22, 19 21, and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation
Hypostatic pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Paralysis agitans

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Percussion and auscultation

(Signed) W B Mayo M. D.

, 19 (Address) Latrobe apt. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kingsville, Md.

DATE OF BURIAL: 7/27/21

20 UNDERTAKER: H. E. Hughes. ADDRESS: 1st N. Broadway

CAUSE OF DEATH: [illegible] TION is very important. See instructions on back of certificates.

D 55678 ✓ D 55678

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 N. Linwood ave ~~St.~~ WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Hihn

(a) RESIDENCE. No. 536 N. Linwood ave ~~St.~~ WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of ~~(or WIFE of)~~ Mary E Hihn

6 DATE OF BIRTH (month, day, and year) April 25th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired Grocer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER John B. Hihn
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Mary Ranch
13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant (Address) Mary E Hihn 536 N. Linwood ave

15 Filed July 27 1921 Robert P. Harrison, Registrar
Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 19 21

17 I HEREBY CERTIFY, That I attended deceased from ~~about~~ July 19 19 21, to July 26 19 21,
that I last saw him alive on July 26 19 21,
and that death occurred, on the date stated above, at 5.10 P. m.
The CAUSE OF DEATH* was as follows:
Artery-Sclerosis, Chronic Interstitial Nephritis and Aortic Stenosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical and other
(Signed) Robt. P. Harrison, M. D.
7/26 1921 (Address) 536 N. Linwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	July 29th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

CAUSE OF DEATH in plain terms, ... TION is very important. See instructions on back of certificates.

27 1921

Spec.—1-10-21—M&T—1500 Bks.

14393 D 55679

HEALTH DEPARTMENT—CITY OF BALTIMORE D 55679

CERTIFICATE OF DEATH.

104

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

2-FULL NAME Joseph O'Connor

(a) RESIDENCE NO. 1019 N. Caroline St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None old
(b) General nature of Industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Frieda Sahlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26-1921

17 I HEREBY CERTIFY, That I attended deceased from June 20-1921 to July 26-1921.
that I last saw him alive on July 26-1921.
and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:
Diarrhea (not dysentery)
(duration) 6 weeks
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) James C. Fox Jr. M. D.
19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery
DATE OF BURIAL July 28 1921
20 UNDERTAKER Henry Hoen & Son
ADDRESS 1201 E Eager St

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

27 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55680

D 55680

CERTIFICATE OF DEATH.

28

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2625 Greenmount Ave. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna. C. Busch

(a) RESIDENCE. NO. 2625 Greenmount Ave. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William. E. Busch

6 DATE OF BIRTH (month, day, and year) Feb. 19. 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James. R. Mettee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Katie Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. William E. Busch
(Address) 2625 Greenmount Ave

15 Filed 7-27-1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-27-1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to July 27, 1921, that I last saw her alive on July 22, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? dont know

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? sputum

(Signed) Martin F. Sloan, M. D.

7.27. 1921 (Address) 414 Prof. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: July-30 1921

20 UNDERTAKER: Henry Strack Son

ADDRESS 2130 E. Eager

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

271921

Spec.—8-24-14—M. & T.—2000 Bks.

D 55681 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55681

CERTIFICATE OF DEATH.

REGISTERED NO. C 27 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 B St Roland Park St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Newton Bosley Parker

(Residence in Baltimore: No. 302 B St Roland Park St.; 4 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Mar. 8, 1917
(Month) (Day) (Year)

7-AGE. 4 yrs. 4 mos. 18 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Newton B. Parker

11-BIRTHPLACE OF FATHER (State or Country), Balto. Co.

12-MAIDEN NAME OF MOTHER, Hazel Klingfelter

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. N. B. Parker

(Address) 302 B St Roland Park

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk Registrar.

271921

Cross out words not important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26 1921 to July 27 1921, that I saw h.. alive on July 27 1921, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Heart Clot

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Thompson M. D.

July 27 1921 (Address) 3632 Roslyn Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge

DATE OF BURIAL, July 28, 1921

20-UNDERTAKER H. S. Marshall

ADDRESS 2539 Eutaw Pl

D 55682

D 55682

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N. Saratoga ST.; 4 WARD)

2-FULL NAME Roberta Barton

(a) RESIDENCE. No. 404 N. Saratoga ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life time ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed or Divorced (write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1856 Aug 8

7 AGE: Years 65 Months .. Days 11 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Employment Agency.

(b) General nature of industry, business, or establishment in which employed (or employer): 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Thaddeus Barton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie Slater

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Pauline Trustfelder

(Address) #23 N. Mulberry St.

15 Filed JUL 27 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1921, to July 26, 1921, that I last saw h.. alive on July 26, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

1 Osteo-Sarcoma over

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No, Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) E. P. Sutton, M. D.

, 19 (Address) 1711 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: July 28 1921

20 UNDERTAKER: Gilbert M. Shriver — ADDRESS: 1015 Edmondson

CAUSE OF DEATH is plain terms, so that a ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of personsengaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Originated in hip.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55683

CERTIFICATE OF DEATH.

150

D 55683

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 N. Gay ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Giuseppina Panzarella

(a) RESIDENCE. No. 1026 N. Gay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 1st 1909

7 AGE 12 Years 5 Months 24 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Paolo Panzarella

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Francesca Arrigo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Paolo Panzarella

(Address) 1026 N. Gay st

15 Filed July 28 1921 Robert P. Harrison, Registrar

L 27 1921 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1921, to July 25, 1921.

That I last saw h[illegible] alive on July 24, 19[illegible].

and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Hydrocephalus

Life (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Jos L Pascucci, M. D.

July 28 1921 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	7/28/21
20 UNDERTAKER	ADDRESS
Geo J Ruth	1735 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Triplett)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55684

D 55684

CERTIFICATE OF DEATH.

115

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1332 Central Av. (ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl H. Triplett

(a) RESIDENCE. NO. 1332 Central Av. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	1	20	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Page H. Triplett

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Rachel Knight

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Page H. Triplett

(Address) 1332 N. Central Av.

15 Filed Robert F. Harrison, Registrar

Burial Permit Clerk.

271921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18 1921. to July 27 1921.

that I last saw h. alive on July 27 1921.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

acute Hypertrophy of Liver

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) J. H. Simms, M. D.

July 27 1921 (Address) 1228 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

London Park July 29 1921

20 UNDERTAKER — ADDRESS

Geo. H. Little 2700 E. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 55685 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55685

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 720 N. Carrollton Ave ST. 16 WARD) REGISTERED No. C. 157

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. N. Lambdin

(Residence in Baltimore: No. 720 N. Carrollton Ave. St.; 17 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, Aug 1, (Month) (Day) 1903 (Year)

7-AGE, 17 yrs. 11 mos. 25 da. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Messenger
(b) General nature of industry, business, or establishment in which employed (or employer) Bank

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Algie Lambdin

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lillian M. Mann

13-BIRTHPLACE OF MOTHER (State or Country), Wisconsin

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Lambdin

(Address) 720 N. Carrollton

15-

Filed JUL 27 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms. It may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. D. Hammond M. D. (Coroner.)

July 27, 1921 (Address) 2502 Eutaw Ave

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....da. In the State ....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, July 28, 1921

20-UNDERTAKER Harry N. Witzke ADDRESS 1531 W Lombard St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55686

D 55686

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.; 4 WARD)

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Wolfrey

(a) RESIDENCE. NO. 618 W Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fletwood Wolfrey

6 DATE OF BIRTH (month, day, and year) Mar. 24 - 1876

7 AGE			If LESS than 1 day, ...hrs. or ....min.
45 Years	4 Months	1 Days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Orange Co Va.

PARENTS

10 NAME OF FATHER Burris Wolfrey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Orange Co Va.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Minority Hospital records. (Address)

15 Filed Robert P. Harrison, Registrar

L 27192 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11 1921 to July 25 1921 that I last saw her alive on July 25 1921 and that death occurred, on the date stated above, at 11:40 p.m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W B Jones, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 28 '21
20 UNDERTAKER	ADDRESS
Harry A. Wirtz & Co	1314 Eutaw

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55687

CERTIFICATE OF DEATH.

104 D 55687

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 W. Saratoga ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Smith

(Residence in Baltimore: No. 730 W. Saratoga St.: yrs., 7 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Dec. 23, 1916 (Month) (Day) (Year)

7-AGE. yrs. 7 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John Smith

11-BIRTHPLACE OF FATHER (State or Country). U S

12-MAIDEN NAME OF MOTHER. Carrie Brooks

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 716 W Saratoga St

15- JUL 28 1921 ROBERT J. BRAUTER Registrar.

Filed ....., 191.... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 26, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14 1921, to July 26 1921, that I saw h him alive on July 25 1921 and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(Duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 4 ds.

(Signed) H. B. Hughes M. D.

7/26, 1921. (Address) 765 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL. July 27, 1921

20-UNDERTAKER. Daniel Easton

ADDRESS 716 Pa ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55688

CERTIFICATE OF DEATH.

REGISTERED NO. D 55688

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 55688
1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 734 Dolphin ST.: 17 WARD)

2-FULL NAME Robert J. Fields Jr.

(a) RESIDENCE. NO. 734 Dolphin ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robert J. Fields, Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anne Whittington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anne Fields
(Address) 734 Dolphin

15 Filed JUL 28 1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1921, to July 26, 1921, that I last saw h mi alive on July 26, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 12 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Widal

(Signed) H. S. McCard M. D.

7/27, 1921 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 28 1921

20 UNDERTAKER John H. Toadvine ADDRESS 142 N. Hilt

Spec.—6-9-19—H. P. Co.—1000 Bks.

55689.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1764 D 55689

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 106 S. Carrollton Ave ST.: 11 WARD)

2-FULL NAME Caroline Booker

(a) RESIDENCE. NO. 106 S. Carrollton Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	A Lone

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Conrad Stumpf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Booker (Address) 106 S. Carrollton Ave

15 Filed ... 19 32 ... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1921, to July 26, 1921, that I last saw her alive on July 26, 1921, and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy) (duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? ? Date of ?

Was there an autopsy? ?

What test confirmed diagnosis? ?

(Signed) M. O'Neill, M. D.

7/27, 1921 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Park — DATE OF BURIAL July 29 1921

20 UNDERTAKER John Feldo — ADDRESS 1200 N Fulton Ave

mation should be entered, CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55690

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 7 Cereal St ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Zawacka (Zawacka)

(a) RESIDENCE. NO. 7 Cereal St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of U

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Ignacy Kowalczyk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Gregorek

(Address) Curtis Bay

15 Filed ....., 19 ..... Local Registrar

AUG 2 1921 Local Form 11 Olof

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27th, 1921, to July 27th, 1921, that I last saw her alive on July 27, 1921, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William Wolff, M. D.

July 27 1921 (Address) 816 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL July 30 1921

20 UNDERTAKER Wm Galloway — ADDRESS 908 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dardas. ✓

D 55691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55691

CERTIFICATE OF DEATH.

102

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Dardas

(a) RESIDENCE. NO. 365 E Denham ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Jacob. Dardas

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank Dix

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Jacob Dardas 306 E Durham St

15 Filed JUL 28 1921 16 ROBERT J. KRUG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26/1921

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1921, to July 26, 1921, that I last saw h[illegible] alive on July 26, 1921, and that death occurred, on the date stated above, at 11.35 a.m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia Gastric Ulcer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/20/21

Was there an autopsy? Yes

What test confirmed diagnosis? Streptococcus Viridans

(Signed) Frank Freeman M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	July 29 1921
20 UNDERTAKER	ADDRESS
Wm Gallaway	1648 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be classified. Do not use abbreviations or initials. Name of contagious disease, if any, must be given. Omission to state the time at which deceased was attended, and the time at which he died, will cause delay. INFORMATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 55692 HEALTH DEPARTMENT—CITY OF BALTIMORE 55692

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lilly Brown. (Leonora Wazesinski)

(a) RESIDENCE. NO. Church St. Curtis Bay ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Stanislaw Wyzesinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Jackulski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant St. Wyzesinski. Curtis Bay
(Address)

15 Filed JUL 28 1921 Robert A. Knauth Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from July 26 1921, to July 27 1921, that I last saw her alive on July 27 1921, and that death occurred, on the date stated above, at 6.53 a. m.

The CAUSE OF DEATH* was as follows:

Ileo colitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Above address

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) W. F. Coleman, M. D.

7/27. 1921 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL July 28 1921

20 UNDERTAKER Wm Fiedelson & Sons

ADDRESS 1148 Eastern

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.--6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55693

CERTIFICATE OF DEATH.

104 D 55693

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 870 S. Lakeas Dr ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Werner

(a) RESIDENCE. NO. 870 S Lakeas Dr ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Whi'c	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) March 6-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Martin Werner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Josephine Mirandy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) German

14 Informant Martin Werner
(Address) 870 S. Lakeas

15 Filed ..... 19 ..... REGISTRAR

AUG 28 192[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17 I HEREBY CERTIFY, That I attended deceased from July 16 1921, to July 27 1921, that I last saw him alive on July 19 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(duration) ....yrs. ....mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) A Fiala, M. D.

July 29 1921 (Address) 2 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 29 1921
UNDERTAKER	ADDRESS
Wm F. Galloway	1618 East

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55694

CERTIFICATE OF DEATH.

120 D 55694

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 632 W North Ave ST.:..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia B Hynson

(a) RESIDENCE. No. 632 W North Ave ST. 12 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. E Hynson

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John H Sanders

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Bucknell

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant Emma S Hynson (Address) 632 W North Ave.

15 Filed ..... 19 ..... Registrar

JUL 28 1921

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to July 27 1921,

that I last saw h[illegible] alive on July 27 1921,

and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? ....

What test confirm[illegible] diagnosis? X

(Signed) Edwin Murray, M. D.

19 (Address) 1221 W. Fayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	July 29 1921

20 UNDERTAKER John O Mitchell ADDRESS 1201 W Fayette St

mation should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55695

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55695

CERTIFICATE OF DEATH.

REGISTERED NO. 43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Wade

(a) RESIDENCE. NO. 1370 N. Fremont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Prince George Co., Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed JUL 28 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12, 19 21, to July 25, 19 21, that I last saw h er alive on July 25, 19 21, and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of July 19th 1921

Was there an autopsy? Not as yet.

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

7/26/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 28th 21
20 UNDERTAKER	ADDRESS
George H. Holland	162 Conant Hilton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificates.
TION is very important. See instructions on back of cert

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history
No of tuberculosis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55696

CERTIFICATE OF DEATH

D 55696

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 4417 Alabama Ave ST. WARD)

2-FULL NAME Ole John Olsen

(a) RESIDENCE. NO. 4417 Alabama Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs — mos. — ds. How long in U. S., if of foreign birth? 40 yrs — mos — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~(or WIFE)~~ of Alida Olsen

6 DATE OF BIRTH (month, day, and year) Apr 5 52

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Paint Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER John Olsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Alida Olsen
(Address) 4417 Alabama Ave

15 Filed JUL 28 1921 ~~REGISTRAR~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1921, to July 26, 1921, that I last saw h~~im~~ alive on July 25 1921, and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

about 4 yrs
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of bladder about 4 yrs
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. S. Hibbett M. D.

July 26 1921 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz's Lem.	July 29 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be understood by persons not physicians. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

55697

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 55697

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 Christian ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred E. Deems

(a) RESIDENCE NO. 2222 Christian ST., 20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Ella Deems

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 069

(b) General nature of Industry, business, or establishment in which employed (or employer): Balto.

(c) Name of employer: Coffee Importer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Edward Deems

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind.

12 MAIDEN NAME OF MOTHER: Jane E. Grady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ire

14 Informant: H. M. Deems

(Address) 2222 Christian St

15 JUL 28 1921 ROBERT P. BRUCE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19 1921 to July 25 1921, that I last saw h— alive on July 25 1921 and that death occurred, on the date stated above, at 11 30 m

The CAUSE OF DEATH* was as follows:

Hemiplegia 1 apoplexy

Arteriosclerosis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Endocarditis Valvular

Acquired (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C Ritch M.D.

1/27 1921 (Address) 215 Hull St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Lawn

DATE OF BURIAL: 7/29 1921

20 UNDERTAKER: J. J. Moran

ADDRESS: E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

by Dutch Wilson and Snakeman

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118 D 55698

55698

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3) Hebrew Hosp St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mame C. Dickens

(a) RESIDENCE. NO. 174 S Park Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: J. E. Dickens

6 DATE OF BIRTH (month, day, and year): May-16-1875

7 AGE: Years 46 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Savanah Ga.

PARENTS

10 NAME OF FATHER: Julius D. Provaseau

11 BIRTHPLACE OF FATHER (city or town) (State or country): Savanah Ga.

12 MAIDEN NAME OF MOTHER: Lula Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga.

14 Informant (Address): J. E. Dickens 1745 Eutaw

JUL 28 1921 19 ROBERT J. KRAUSS Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 19 21

17

I HEREBY CERTIFY, That I attended deceased from 7-25 1921 to 7-26 1921

that I last saw h[illegible] alive on 7-26 1921

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Shock.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Hemorrhagic Pancreatitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? Yes Date of 7-25-21

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) Louis Sachs, M. D.

7-26 1921 (Address) The Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Savannah, Ga. DATE OF BURIAL 7/28 1921

20 UNDERTAKER: J. J. Moran ADDRESS 300 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Use no abbreviations or ditto marks. Statement of contributory cause of death may be required. See instructions on back of certificates. TION is very important.

Spec.—6-1-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55699

CERTIFICATE OF DEATH.

D 55699

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2930 Guilford Ave. ST.: | 7 | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Heise

(a) RESIDENCE. NO. 2930 Guilford Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Helen Heise

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer) Stove Mfg.

(c) Name of employer A. Weiskettle Co.

9 BIRTHPLACE (city or town) (State or country) Balto. City, Md.

PARENTS

10 NAME OF FATHER Wm. Heise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Lentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Helen Heise (Address) 2930 Guilford Ave.

15 Filed JUL 28 1921 Burial Permit Given

CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 27, 19 21, to July 29, 19 21, that I last saw him alive on July 29, 19 21, and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Fractured Femur

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Stein, M. D.

(Address) 10 W. Mary, Emergency

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wood Lawn Cem.	July 29 19

20 UNDERTAKER Wm. C. Black, ADDRESS 927 N. Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D 55700

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55700

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1213 W. Fayette ST.; 18 WARD) REGISTERED NO. C 1779

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Auer

(Residence in Baltimore: No. 1213 W. Fayette St.; 67 yrs., 5 mos. 8 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Feb. (Month) 19 (Day), 1854 (Year)

7-AGE. 67 yrs. 5 mos. 8 da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dentist 65
(b) General nature of industry, business, or establishment in which employed (or employer): Dentistry

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, August Auer

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Kaufer

(Address) 1213 W. Fayette St.

15- Filed JUL 28 1921, 191 ROBERT J. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1917, to July 27 1921. that I saw him alive on July 27 1921. and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) 4 yrs. 6 mos. 3 da.

CONTRIBUTORY (Secondary) Arteriosclerosis & Chronic Myocarditis

(Duration) About 2 yrs. 6 mos. 0 da.

(Signed) Harry L. Ortz M. D.

July 28, 1921. (Address) 1223 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, July 30, 1921.

20-UNDERTAKER Jos Joerdens Son ADDRESS 217 S. Broa

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 55701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55701

CERTIFICATE OF DEATH.

9 79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2000 Robb St ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William T. Tudor

(a) RESIDENCE NO. 2000 Robb ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Caroline Tudor

6 DATE OF BIRTH (month, day, and year) June 12 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipefitter 059

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Tudor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Anna Dearborn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Caroline Tudor

(Address) 2000 Robb St

15 Filed JUL 28 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27- 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25 , 1921 , to July 27. 1921.

that I last saw him alive on July 26 , 1921

and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis, Mitral insufficiency & acute dilatation

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Blyden, M. D.

, 19 (Address) 1100 E Northam

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL July 30 1921

20 UNDERTAKER Wm Cook Sons & North ADDRESS

IMPORTANT—Fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or symbols. Your CERTIFICATE is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55702

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 55702

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 2423 Ettin ST.; 14 WARD)

2-FULL NAME John Thomas Bolden

(a) RESIDENCE NO. 2423 Ettin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. 8 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 21 20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jno Bolden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Highmy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Henrietta Bolden
(Address) 2423 Ettin

15 Filed JUL 28 1921 Burial Permit [illegible] (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1921, to July 27, 1921, that I last saw him alive on July 27, 1921, and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Ac. Entero colitis
10 days

(duration) yrs., mos. ds.

CONTRIBUTORY (Secondary) Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Camp Lee

Did an operation precede death? No Date of —

Was there an autopsy? No Objective Symptoms

What test confirmed diagnosis?

(Signed) Edw Shoff, M. D.

19 (Address) 18 1/2 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carburn — DATE OF BURIAL JUL 29 1921

20 UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that a physician may be able to classify it. Do not use abbreviations or terms not generally understood. Cause of death may be entered by the physician in the space provided for "Remarks" on back of certificates. See instructions on back of certificates. INFORMATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55703

D 55703

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 113 S. Wolf St. ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabella White

(Residence in Baltimore: No. 113 E. Wolf St. St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 24 (Day), 1857 (Year)

7-AGE, 64 yrs. mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joshua Chalk

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Henrietta Harris

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. A. Chase

(Address) 942 Druid Hill

15-

Filed JUL 28 1921, 191.....

ROBERT P. KRAUTER
Registrar.

Burial Permit Issued

CAUSE OF DEATH must be plainly written. All questions must be answered if important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July - 3 - 1921, to July - 25 - 1921, that I saw her alive on July - 25 1921, and that death occurred, on the date stated above, at 9 30 p. m.

The CAUSE OF DEATH* was as follows:

1st Heat - Exhaustion

(Duration) ..... yrs. 3 Wks. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Harold Brooks M. D.

July 26, 1921. (Address) 1305 Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, July 29, 1921

20-UNDERTAKER John H. Toadvine — ADDRESS 1432 Ashe St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55704 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55704

CERTIFICATE OF DEATH. 1479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1809 McCulloh (St.) 14 (Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cassie Gorry

(a) RESIDENCE. NO. 1809 McCulloh St ST., ... WARD.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	Dont Know		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant (Address) Old Home 1809 McCulloh St

15 Filed JUL 28 1921 ROBERT J. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1924, to July 26, 1924, that I last saw her alive on July 26, 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) Dont Know ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W T Gorsuch, M. D.

7-28-1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 28 1921

20 UNDERTAKER Sam H Taddeus ADDRESS 142 Ashland

CAUSE OF DEATH in plain terms, so that it may be properly CLASSIFIED. EXAMINE other side of certificate. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Deahl

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55705

CERTIFICATE OF DEATH. X 50

D 55705

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie M. Deahl

(Residence in Baltimore: No. Nursery Lane Catonsville St.: RD yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Sept 7th, 1866 (Month) (Day) (Year)

7-AGE, 54 yrs. 10 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country), Stanton Virginia

PARENTS.

10-NAME OF FATHER, N. C. Gregory

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Sally Grove

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Deahl

(Address) Catonsville

15- Filed JUL 28 1921, 19..., ROBERT A KRAUTER Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omissions will cause delay. Be particular and exact. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23 1921, to July 26 1921, that I saw h[illegible] alive on July 26, 1921, and that death occurred, on the date stated above, at 2.40 A m.

The CAUSE OF DEATH* was as follows:

Leukocytemia — etiology unknown

(Duration) ...yrs. ...mos. 7 ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(Duration) ...yrs. ...mos. ...ds.

(Signed) Frank Wentworth M. D.

July 28, 1921. (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 4 ds. In the State ? yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Nursery Lane Catonsville

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery — DATE OF BURIAL. July 28 1921

20-UNDERTAKER, B. B. Hepburn — ADDRESS 2236 Frederick Ave

Spec.—1-10-21—M&T—1500 Bks.

Carrie Johson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55706

14963-3
D 55706

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 24 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Johnson

(a) RESIDENCE NO. 1121 Hull St. Town Point Md. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ~~[illegible]~~ mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 16-1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17			

8 OCCUPATION OF DECEASED Cigar box.

(a) Trade, profession or particular kind of work Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Victor Johnson.

11 BIRTHPLACE OF FATHER (city or town) Sweden
(State or country)

12 MAIDEN NAME OF MOTHER Anna Tennant

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Johns Hopkins Hospital Records.
(Address)

15 Filed JUL 28 1921 19 ROBERT P. KRAUTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1921, to July 26, 1921, that I last saw h[illegible] alive on July 26, 1921, and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Emphysema (Replacement)
Bronchopneumonia
General Peritonitis

(duration) yrs. moa 7 ds.

CONTRIBUTORY (Secondary) Abuse
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto, Md

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Path. findings

(Signed) T. H. Flennaken M. D.

7-27-21 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL July 29 1921

20 UNDERTAKER J. Herzog & Co

ADDRESS 2008 Orleans

mation should be carefully supplied. Exact statement of occupation is necessary. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is necessary. If TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous. Cause of peritonitis unknown. Bronchopneu. which resulted in empyema.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55707

CERTIFICATE OF DEATH.

63-001

D 55707

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD 9)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Roland Donald

(a) RESIDENCE. NO. 1320 Wirt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Donald

11 BIRTHPLACE OF FATHER (city or town) (State or country) H. Michaels Md.

12 MAIDEN NAME OF MOTHER Addy M. Kuhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mrs D. Donald 1320 Wirt St.

15 Filed JUL 28 1921 19 ROBERT I. KRAUSE Registrar

Burial Permit Oliver

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1921, to July 27, 1921, that I last saw him alive on July 27, 1921, and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Poliomyelitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Lumbar punctures

(Signed) Bulla Pearson, M. D.

(Address) Sydenham Hospital 7/27/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	7/28/21
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1733 Hanford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55708 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55708

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1029 Valley St. ST.: 10 (WARD) 20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Coffey

(a) RESIDENCE. NO.... 1029 Valley ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Coffey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Kenny
(Address) 1029 Valley St.

15 Filed JUL 28 1921 JOHN J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 21. 1921. to July 26. 1921.
(that I last saw her alive on July 25. 1921.
and that death occurred, on the date stated above, at 10.20 a. m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis (duration) ~~3 1/2~~ yrs. 3 1/2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic Chemical

(Signed) Mary F. Vaughan M. D.

. 19 (Address) 1028 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	July 30 1921

20 UNDERTAKER ADDRESS

J. C. Wiedefeld 914 Gramont Ave

IMPORTANT—Information should be carefully written in ink, so that it may be properly classified. Exact statement of DECEASED'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55709

CERTIFICATE OF DEATH.

104-91 D 55709

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Hebrew Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Dubowitz

(a) RESIDENCE. NO. 1610 Abbot ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	✓

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) December 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8		

8 OCCUPATION OF DECEASED ✓ None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry Dubowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Levy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1411 E. Baltimore St.

15 Filed JUL 28 1921 19 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27/21 19

17 I HEREBY CERTIFY, That I attended deceased from July 19 . 19 21. to July 27 . 19 21.
that I last saw him alive on July 27 . 19 21.
and that death occurred, on the date stated above, at 9.55 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Intestinal Indigestion

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Zinberg, M. D.

7/27 19 21 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL July 28 1921

20 UNDERTAKER Jack Lewis, 1411 E. Balto

ADDRESS

Information should be legibly supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—4-9-19—H. P. Co.—1000 Blks.

D 55710 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55710

CERTIFICATE OF DEATH. 28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1306 Webb ST.: 10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Meyers

(a) RESIDENCE: NO. 1306 Webb ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) 670
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city

PARENTS

10 NAME OF FATHER Jame Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Jno Simms 1306 Webb St

15 Filed AUG 28 1921 ROBERT I. KRAUTER Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26- 1921

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1921, to July 24, 1921.

that I last saw her alive on July 24, 1921.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tb (chronic)

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? N Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) A. G. Hornstein, M. D.

(Address) 733 Linwell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 28th 1921

20 UNDERTAKER ADDRESS

P. B. Goetz 1405 McCulloh St

Spmc.—6-9-19—H. P. Co.—1000 Bks.

D 55711 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55711

CERTIFICATE OF DEATH.

REGISTERED NO. 8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 N. Castle ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Girard Anthony Back.

(a) RESIDENCE No. 211 N. Castle ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant.

6 DATE OF BIRTH (month, day, and year) March 11th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John A. Back

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Rosenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) John A. Back. 211 N. Castle St.

15 Filed JUL 28 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27th 1921

17

I HEREBY CERTIFY, That I attended deceased from July 12 1921 to July 27 1921.

that I last saw him alive on July 27 1921.

and that death occurred, on the date stated above, at 4:10 P m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Oedema & Lung

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenlon M. D.

1921 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	July 28 1921
20 UNDERTAKER Lilly & Guier	ADDRESS 400 S. Mosher St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

14967 8 D 55712

HEALTH DEPARTMENT—CITY OF BALTIMORE D 55712

CERTIFICATE OF DEATH.

1 6 138

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 196 WARD)

2-FULL NAME Anna Katschenreuter Balto Md.

(a) RESIDENCE No. 3303 Philadelphia Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of August Katschenreutter

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H-Work 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Hofstetter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Carr.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Johns Hopkins Hospital (Address) Baltimore

15 Filed JUL 28 1921, 19 BOARD OF HEALTH Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to July 26, 1921, that I last saw her alive on July 25, 1921, and that death occurred, on the date stated above, at 2 P a. m.

The CAUSE OF DEATH* was as follows:

Puerperal eclampsia

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Guy N. Bromwell, M. D.

7/26, 1921 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem

DATE OF BURIAL July 29 1921

20 UNDERTAKER Lilly & Zeile

ADDRESS 403 S. Wolfe St

mation should be carefully supplied. Avoid abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55713

154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Conway

(a) RESIDENCE. NO. 415 East 20th ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. — ds. How long in U. S., if of foreign birth? 41 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dan'l Conway

6 DATE OF BIRTH (month, day, and year) (?) 1824

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	97(?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER (?)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Kept Private (Address) Mercy Hospital

15 Filed JUL 28 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1913, to July 27, 1921, that I last saw h[illegible] alive on July 27, 1921, 3:15 P. m. and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (acute) 5 to 2

Pulmonary Embolism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hospital.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Chas. J. Eberly, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	7/29/21

20 UNDERTAKER George A. Imhof ADDRESS Fulton & Lafayette

mation should be carefully supplied. Exact statement of facts may be properly classified. Exact statement of facts may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55714 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55714

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2141 Linden Ave (St.) 13 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Stern

(a) RESIDENCE. No. 2141 Linden Av St.. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? [illegible] yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Ida Stern

6 DATE OF BIRTH (month, day, and year) Aug. 12 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Business

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jacob Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rubenzon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germ

14 Informant Ida Stern
(Address) 2141 Linden

15 Filed JUL 28 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20. 1921. to July 27. 1921.

that I last saw h[illegible] alive on July 27. 1921.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Symptoms (duration) 1 yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) Louis P. Hamburger, M. D.

July 28. 1921 (Address) 1707 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	July 29 1921
20 UNDERTAKER	ADDRESS
Harry Goodman	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact [illegible] TION is very important. See instructions on back of certificates.

Smedes

D 55715

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55715 HEALTH DEPARTMENT—CITY OF BALTIMORE

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat St. 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Otis Smedes

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Of Mr Smedes

6 DATE OF BIRTH (month, day, and year) Unknown 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Town Falls Mass

PARENTS

10 NAME OF FATHER George A. Otis

11 BIRTHPLACE OF FATHER (city or town) Boston (State or country) Mass

12 MAIDEN NAME OF MOTHER P.C Bawey

13 BIRTHPLACE OF MOTHER (city or town) Norton Town Falls (State or country) Mass

14 Informant (Address) Records of Mt Hope Retreat Norton Mass.

15 1921 Robert F. Harrison, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3rd 1920, to July 29, 1921, that I last saw h[illegible] alive on July 28, 1921, and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -

Abt

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia Senile -

Abt (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Washington DC

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Cannery, M. D.

. 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Raleigh N.C. DATE OF BURIAL July 29/ 1921

20 UNDERTAKER STEIN-HOWER COMPANY (Address) [illegible] ADDRESS 1400 EUTAW AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

D 55716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55716

CERTIFICATE OF DEATH.

10 104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1410 Mc Henry ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warren G. Harding Bowers

(Residence in Baltimore: No. 1410 Mc Henry St.; yrs., mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Mal	colo	Sigle

6-DATE OF BIRTH, Nov 19, 1920
(Month) (Day) (Year)

7-AGE. ....yrs. 8 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none yet
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Wm H Bowers

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Carrie [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cary Bowers

(Address) 1410 McHenry St

15- Filed JUL 29 1921, 191.. ROBERT J KRAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis Colitis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James H Kenton M. D.
(Coroner.)

July 29 1921 (Address) 701 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Ashbury M E Cem	7-29, 1921.
20-UNDERTAKER	ADDRESS 115 Calhoun st
ROBERT BROOKS & SON FUNERAL DIRECTORS & EMBALMERS	

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55717

D 55717

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 Evan Chapel Road ST.; 12th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine A. Phipps

(Residence in Baltimore: No. 30 Evan Chapel Road St.; 81 yrs. 6 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... Jan (Month) 14 (Day), 1840 (Year)

7-AGE 81 yrs. 6 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Theodora Mace

11-BIRTHPLACE OF FATHER (State or Country), Balto. City

12-MAIDEN NAME OF MOTHER Asked Mr. Known

13-BIRTHPLACE OF MOTHER (State or Country) Asked Not Known

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs D W Stanbaugh

(Address) 30 Evan Chapel Rd

15- Filed JUL 29 1921, 191.... ROBERT P. KRAUTER Registrar. Burial Permit Issued

CAUSE OF DEATH to be written in plain terms, so that every item may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 29 (Day), 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from Feb 28 1921, to July 29 1921, that I saw her alive on July 28 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Left Hemiplegia - Cerebral Embolism (Duration) 3 yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (Duration) — — 4 ds.

(Signed) M. J. Porter M. D.

7/29, 1921 (Address) 422 Rolandeve

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery — DATE OF BURIAL, Aug 1, 1921

20-UNDERTAKER R S Marshall — ADDRESS 3537 Fall Rd

Spec.—8-24-14—M. & T.—2000 Bks.

D 55718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55718

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Taney Road ST.; WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles T. Merritt (Or, if child, of Father) (65 yrs., mos. ds.)

(Residence in Baltimore: No. 3 Taney Road St.;

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-If MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White	Married

6-DATE OF BIRTH, June (Month) 23 (Day) 1863 (Year)

7-AGE, 57 yrs. 6 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Pattern Maker (b) General nature of industry, business, or establishment in which employed (or employer): U.S.

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Thomas Merritt

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER, Rebecca Lee

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ida C. Merritt

(Address) 3. Taney Road

15- Filed JUL 29 1921 191.... Burial Permit Issued Registrar.

CAUSE OF DEATH to be plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 22 1921, to July 28 1921, that I saw h.m alive on July 28 1921, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral Hemorrhage)

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (Duration) 2 yrs. mos. ds.

(Signed) Wm. D. Butler M. D.

July 29, 1921. (Address) 4754 Park Heights Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Mary's. DATE OF BURIAL, July 29, 1921

20-UNDERTAKER H. S. Marshall ADDRESS 3539 Falls Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55719

CERTIFICATE OF DEATH.

39 D 55719

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 740 S. Potomac ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Burns

(a) RESIDENCE. No. 740 S. Potomac ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred, Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Elizabeth Burns

6 DATE OF BIRTH (month, day, and year): Feb 4-1857

7 AGE — Years: 64 Months: 5 Days: 23
If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cr. Theater
(b) General nature of industry, business, or establishment in which employed (or employer): 186
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS
10 NAME OF FATHER: William Burns
11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland
12 MAIDEN NAME OF MOTHER: Mary Connors
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Theresa Burns
(Address): 740 S. Potomac

15 Filed JUL 29 1921, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 17th, 1921, to July 27th, 1921, that I last saw him alive on July 26th, 1921, and that death occurred, on the date stated above, at 7:25 P m.

The CAUSE OF DEATH* was as follows:

Cancer of the tongue
(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ——

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Schwatka, M. D.
, 19 (Address) 734 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland — DATE OF BURIAL: July 30 1921

20 UNDERTAKER: William Cook — ADDRESS: S. & Bath

mation should be carefully supplied. Any omission CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of c

be properly classified. Exact statement of OCCUPA of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 64 D 55720

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Woodyear Dr ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Saphia Smallwood

(a) RESIDENCE. NO. 1715 Woodyear ST., WARD. Easton Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow Zinkan

6 DATE OF BIRTH (month, day, and year)

7 AGE: 18 yrs — — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Caroline Co. Md

PARENTS

10 NAME OF FATHER: Jones Dandridge

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Mollie J. Stanley
(Address) 1715 Woodyear Pl

15 Filed JUL 29 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/15 1921 to 7/28 1921

that I last saw her alive on 7/28 1921

and that death occurred, on the date stated above, at 2 20 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ..... yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Rhetta, M. D.

, 19 (Address) 2/29 Dixon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Md — DATE OF BURIAL: July 30th 1921

20 UNDERTAKER: Geo H Holland — ADDRESS 163 Dennis Ave

mation should be carefully supplied. Any abbreviation may be properly classified. Exact statement of
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55721

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55721

CERTIFICATE OF DEATH.

64-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Rittershofer

(a) RESIDENCE. No. 2011 E. Oliver St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Rittershofer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed JUL 29 1921 ROBERT J. BRUTER Registrar

Burial Cert. Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1921, to July 26, 1921, that I last saw her alive on July 26, 1921, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Mitchell, M. D.

7/27/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	7/30 1921
20 UNDERTAKER	ADDRESS
Albert L. Hitz Jr.	1606 N. Chester St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

D 55722

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55722

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 64 St. Joseph Hospital WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Nicholas Demerlein

(Residence in Baltimore: No. 1732 Fairmount Ave St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH. March 1, 1842
(Month) (Day) (Year)

7-AGE. 79 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Nicholas Demerlein

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Mrs Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Demmerlein

(Address) 1732 Fairmount Ave

15- Filed JUL 29 1921 191.. ROBERT J. BRAUER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest on the body (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin Ingles M. D.
(Coroner)

7-28-1921 (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Most Holy Redeemer — DATE OF BURIAL. July 30, 1921

20-UNDERTAKER Kendall Keppel & Son — ADDRESS 37 S. Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Infant Turner.

D 55723

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 309 N Gilmor St. 19 WARD)

REGISTERED No. C 1570

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Evon~~ Turner

(Residence in Baltimore: No. 309 N Gilmor St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, July (Month) 28 (Day), 1912 (Year)

7-AGE, ... yrs. ..... mos. ..... da.

If LESS than 1 day, 2 hrs. or .... min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Herbert Turner

11-BIRTHPLACE OF FATHER (State or Country). Balto md

12-MAIDEN NAME OF MOTHER Evon Hymon

13-BIRTHPLACE OF MOTHER (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evon Turner

(Address) 309 N Gilmor St.

15-

Filed JUL 29 1921 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Inanition

Foreman Ortch

..... (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... da.

(Signed) James H. Fenlon M. D. (Coroner.)

7-27-, 1921 (Address) 720 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Laurel Cemtry	July 29, 1921
20-UNDERTAKER Felix B. Pyz	ADDRESS 1021 Mulberry St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55724

CERTIFICATE OF DEATH.

4 X 79 D 55724

REGISTERED NO.

1-PLACE OF DEATH University Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO University Hosp. ST.: 4 WARD)

2-FULL NAME Eli Edson

(a) RESIDENCE NO Howard County WARD Ellicott City

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah E. Edson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about 70				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer on farm

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant William Edson (Address) Howard County

15 Filed JUL 29 1921 19... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to July 27, 1921, that I last saw him alive on July 27, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ... yrs. ... mos. 30 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) ... M. D.

. 19 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Cemetery

DATE OF BURIAL: July 30 1921

20 UNDERTAKER: Remsenberg Station

ADDRESS: 3617 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fill in all items. Use ditto marks (") only when they will not be misunderstood. Do not use abbreviations or initials. Write plainly in ink. Do not write on back of certificates.
TION is very important. See instructions on back of certificates.

Spec—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55725

CERTIFICATE OF DEATH.

120

D 55725

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (NO. 2527 N. Baltimore ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Anderson.

(a) RESIDENCE. NO. 2527 N. Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): March 11 - 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer): City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs. Phelps 2527 N. Baltimore

15 Filed JUL 29 1921 19 ROBERT I. KRAUTER Registrar

Burial Permit Oiven

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to July 28, 1921, that I last saw h[illegible] alive on July 28, 1921, and that death occurred, on the date stated above, at 7:20 P.M.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis (duration) yrs. last known mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Martin A. Cox, M. D.

July 29, 1921 (Address) 537 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	7/30 1921
20 UNDERTAKER	ADDRESS
J. Frew McCully	130 C. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Three.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55726

D 55726

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph. G Lee

(a) RESIDENCE NO. 209 E. 24th St Balto ST. Md WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male.	White	Singles.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph G Lee.

11 BIRTHPLACE OF FATHER (city or town) (State or country) new york.

12 MAIDEN NAME OF MOTHER Helen Lepp.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Johns Hopkins Hospital (Address) Baltimore

15 Filed JUL 29 1921 ROBERT J. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1921

17

I HEREBY CERTIFY, That I attended deceased from July 27. 1921, to July 28, 1921, that I last saw him alive on July 28, 1921, and that death occurred, on the date stated above, at 4:10 a m.

The CAUSE OF DEATH* was as follows:

Atresia of the oesophegus
Congenital malformation

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY — (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 27, 1921

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. C. Davison, M. D.

7-29-1921 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's	July 29, 21
20 UNDERTAKER	ADDRESS
C. A. Weagley	501 E 22

mation should be clearly supplied. Exact and full name should be given. Residence must be properly classified. Every question must be answered. Physicians are required to report CAUSE OF DEATH in plain terms, so that it may be properly classified. Indefinite terms, such as "Debility," "Old Age," "Exhaustion," etc., are not sufficient. INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 55727 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55727

CERTIFICATE OF DEATH.

REGISTERED NO. 169

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 815 S. 5th ST., 26 (WARD) Kelly-Spall Funeral Home

2-FULL NAME Charles Gillease

(a) RESIDENCE No. 815 S. 5th ST., 26 WARD

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Boarding House

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 29-1921

7 AGE: Years ... Months ... Days ... If LESS than 1 day 2 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Gillease

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Anna Heuland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: James Gillease

(Address) 815 S. 5th St

15 Filed JUL 29 1921 Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7. 29. 1921

17 I HEREBY CERTIFY, That I attended deceased from 7 29 .1921. to 7 29 .1921.

that I last saw h— alive on 7 29 .1921

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Spontaneous Birth now Drowning in Bucket

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Statement

(Signed) A B Fetterow M. D.

7/29. 1921 (Address) 315 S. Highland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem.

DATE OF BURIAL: July 29 1921

20 UNDERTAKER: Lilly and Zeih

ADDRESS: 403 S. Wolfe

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55728

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55728

CERTIFICATE OF DEATH.

63

REGISTERED NO. C.....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE, (No. 822 N. Carrollton ave ST. ..... WARD)

2-FULL NAME Katharine Hamilton Luckett

(Residence in Baltimore: No. 822 N. Carrollton ave St.: 75 yrs., 11 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 7, 1845
(Month) (Day) (Year)

7-AGE, 75 yrs. 11 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Roger B. Luckett

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Margaret White

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Georgiana Gifford

(Address) 822 N. Carrollton ave.

15- Robert P. Harrison,

Filed ..... 191..... Burial Permit Clerk. Registrar.

JUL 29 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20- 1920, to July 28- 1921, that I saw h- alive on July 28- 1921, and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Mitralis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Paralysis of micturition about 6 mths

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. W. Cook M. D.

July 28-, 1921. (Address) 1107 N. Carrollton ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Greenmount Cemetery

DATE OF BURIAL, July 30. 1921

20-UNDERTAKER Chas. G. Black

ADDRESS 742 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 55729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55729

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2908 N. Calvert St., (WARD) 17

2-FULL NAME Alice Cousins

(a) RESIDENCE NO. 2908 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hurrain J. Cousins

6 DATE OF BIRTH (month, day, and year) Feb 18 1852

7 AGE Years 69 Months 5 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John A. Mosher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Charlotte Farmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Gardner (Address) 2908 N Calvert

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28 1921

17 I HEREBY CERTIFY, That I attended deceased from 7/25, 1921, to 7/28, 1921, that I last saw her alive on 7/28, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) Many yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Stanley Gorsuch M.D.

, 19 (Address) 2900 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dremont

DATE OF BURIAL July 30, 1921

20 UNDERTAKER William Cook

ADDRESS 502 E North

Exact statement of occupation should be carefully supplied. AGE must be given in all cases, and it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55730

CERTIFICATE OF DEATH.

D 55730

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 3401 Fairview Ave., Forest P. St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME CHARLES OTIS TYDINGS, JR.

(Residence in Baltimore: No. 3401 Fairview Av., Forest Park St.: 0 yrs., 5 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, February (Month) 6th (Day), 1921 (Year)

7-AGE, 0 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Charles Otis Tydings

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER Helen Van Zandt

13-BIRTHPLACE OF MOTHER (State or Country). M. D.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Tydings

(Address) 3401 Fairview Ave.

15- Robert P. Harrison,

Filed....., 191..... Burial Permit Clerk Registrar.

JUL 29 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 29th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 5th, 1921, 191..., to July 29, 1921 191..., that I saw h.. alive on July 20th, 1921 191..., and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary and generalized.

(Duration) 0 yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(Duration) 0 yrs. 0 mos. 14 ds.

(Signed) Benjamin Tappan M. D.

July 29, 1921, 191... (Address) 1102 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Dorsey Lawyers Circle	July 30, 1921.
20-UNDERTAKER.	ADDRESS
Joseph Tyler Sons	13 & Light Sts

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Form 8-9-19 H. F. Co. 1000 Pks.

D 55731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55731

CERTIFICATE OF DEATH.

5 91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.; 50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Williams

(a) RESIDENCE. NO. 7 N. Eden St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Maggie Roller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Maryland

14 Informant (Address) Hospital Records, New City Hospital. UNIVERSITY OF MARYLAND

15 Filed JUL 29 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1921, to July 25, 1921, that I last saw him alive on July 25, 1921, and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows: over

1 Broncho-Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of July 8th 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

7/26/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL JUL 29 1921

20 UNDERTAKER Commissioner Health. ADDRESS

Per Wm. S. Woodall

motion should be carefully supplied. Exact statement of facts may be properly classified. Exact statement of facts may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55732

D 55732

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hosp. - ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Likke.

(a) RESIDENCE. NO. St. V. C. Hosp. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 2- 1920

7 AGE 1 Years 3 Months 25 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. none.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Robert P. Harrison.

15 Filed ..... 19 ..... Registrar

JUL 29 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17 I HEREBY CERTIFY. That I attended deceased from July 20 . 1921 . to July 27 . 1921 . that I last saw h.. alive on July 27 . 1921 . and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows: Acute Suppurative Ileocolitis

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) ..... yrs. — mos. 12 days.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Emil A. Krug M. D.

. 19 (Address) 2062 E. Fallsway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JUL 29 1921 19
20 UNDERTAKER Commissioner Health,	ADDRESS

mation should be carefully supplied. Any unknown CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55733 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55733

CERTIFICATE OF DEATH. 31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roosevelt Suggs

(a) RESIDENCE. NO. 1413 McElderry St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boot-Black

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Charlie Suggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lula Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records.
(Address) New City Hospital.

15 Filed Robert P. Harrison, 19 Registrar

L 29192 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1921

17 I HEREBY CERTIFY, That I attended deceased from June 30 1921, to July 28 1921, that I last saw him alive on July 27, 1921, and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Intercolous Peritonitis

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

7/28/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	7/30/21
20 UNDERTAKER	ADDRESS
R C Gross	1405 McElderry

mation should be careful, especially as to use of proper terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55734

CERTIFICATE OF DEATH.

79 D 55734

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4411 Gruenway ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Rollen Murray

(Residence in Baltimore: No. 4411 Gruenway St.; 72 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH, Nov. 12, 1828. (Month) (Day) (Year)

7-AGE, 92 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Henry G. Murray

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Eliza Billyer

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. R. Murray

(Address) 4411 Gruenway

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

JUL 29 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1917 191 , to July 27th, 1921, that I saw him alive on July 27th, 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Arter. Sclerosis & Mary
Heart with Senile Weak

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Exhaustion (Duration) yrs. mos. 10 ds.

(Signed) Wilmer Brinton M. D.

July 29th 1921 (Address) Calvert & Fayette Sts.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, July 30, 1921

20-UNDERTAKER Chas. E. Zauch

ADDRESS 802 Madison Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item is important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 55735 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55735

D 55735

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH Washington Park.

CITY OF BALTIMORE: (No. N.W.Cor. Cascade & Delmont ST.; 11th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Elizabeth M. Boone

(Residence in Baltimore: No. 856 W. Baltimore St.; 21 yrs., 6 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH. Jan. (Month) 17 (Day), 1900 (Year)

7-AGE. 21 yrs. 6 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: House wife (b) General nature of industry, business, or establishment in which employed (or employer): 837

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Louis Hartman

11-BIRTHPLACE OF FATHER (State or Country). Baltimore City

12-MAIDEN NAME OF MOTHER Mary Wiegent

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A. Boone

(Address) 856 W. Balto. St

15- Robert P. Harrison, Registrar.

AUG 9 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1921, to July 28 1921, that I saw her alive on July 28 1921, and that death occurred, on the date stated above, at 7.10 p.m.

The CAUSE OF DEATH* was as follows:

(a) Phthisis Pulmonalis

(Duration) X yrs. 9 mos. X ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) 1 yrs. 1 mos. X ds.

(Signed) P. B. Wilson M. D.

7/30, 1921 (Address) 1124 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Aug. 1, 1921
20-UNDERTAKER George J. Smith	ADDRESS 1000 Fayette Ave

N.B.—Every item of information must be properly classified. Every item must be filled in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55736 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55736

CERTIFICATE OF DEATH.

X 61-0

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1220 Hull ST.: 24 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas V Dunn

(a) RESIDENCE. NO. 1220 Hull ST., 24th WARD. Bloomfield N.J.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) July 28 1916

7 AGE Years 4 Months 11 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bloomfield N.J.

PARENTS

10 NAME OF FATHER John Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Cath Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash D.C.

14 Informant Cath Dunn 1220 Hull St.

15 Filed 1927 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 1921, to July 28, 1921, that I last saw h. alive on July 23, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Inanition (over).

(duration) 0 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Cerebro Spinal Meningitis

(duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1041 Riverside Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 7/30 1921

20 UNDERTAKER: Joseph F. Lahey & Son

ADDRESS: 19 Eight St.

Information should be carefully supplied. AGE should be properly classified. Exact statement of occupation is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is necessary. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

149628
D 55737

HEALTH DEPARTMENT—CITY OF BALTIMORE D 55737

CERTIFICATE OF DEATH. X 150

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank M. Carr

(a) RESIDENCE NO. 996 Central Av. Plainfield N.J. WARD Plainfield N.J.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 16-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Frank Carr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Eleanor M. Goff.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUL 30 1921, 19 Robert P. Harrison, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1921, to July 30, 1921, that I last saw h[illegible]ive on July 30, 1921, and that death occurred, on the date stated above, at 3.45 m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus.

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 7/27/21

Was there an autopsy? Yes.

What test confirmed diagnosis? elimination of Dis.

[Signed] Henry H. Thomas Jr. M. D.

(Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Plainfield N. J. DATE OF BURIAL July 30 1921

20 UNDERTAKER H. J. Tickner & Sons ADDRESS Penna Ave

mation should be carefully supplied. Exact statement of occupa
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55738

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55738

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1605 Cliftview Ave. (ST.) 8 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Martin Horn.

(a) RESIDENCE. (No.) 1605 Cliftview Ave (ST.) (WARD.)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 27 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jul 2nd 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

000

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George W: Horn

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Louise Teges

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Louise Horn
(Address): 1605 Cliftview Ave

15 [illegible]: Robert P. Harrison, Registrar
Burial Permit Clerk.

JUL 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jul 29 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1921 to July 29, 1921 that I last saw h[illegible] alive on July 28, 1921 and that death occurred, on the date stated above, at ? a. m.

The CAUSE OF DEATH* was as follows:

Inanition — (Delirium at 8 months)

(duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Post mortem

(Signed) Benj. D. Hayden, M. D.

7/29 1921 (Address) 1216 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 30 1921
20 UNDERTAKER	ADDRESS
J. Kemig & Co	208 Aisquith

IMPORTANT.—WRITE PLAINLY. Information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55739

D 55739

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 105 W. Ostend St. St.: 23 WARD)

2-FULL NAME Emma E. Varina

(a) RESIDENCE. NO. 105 W. Ostend St. ST., ..WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William N. Varina

6 DATE OF BIRTH (month, day, and year) June 13th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Susie Carson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. Charles Schuerholtz
(Address) 105 W. Ostend St.

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27th 1924

17 I HEREBY CERTIFY, That I attended deceased from June 19 24 to July 27 1924, that I last saw h[illegible] alive on July 26 1924, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Ulcer

(duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edw Cornuth, M. D.

7/28 1924 (Address) 517 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL July 30 1924

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Patterson Park Ave

MARGIN RESERVED FOR FILING NO. A PERMANENT RECORD. Every item must be written N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. Every item of information should be stated EXACTLY. AGE should be carefully supplied. PHYSICIANS should be specific in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DL 30 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55740

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 W. Hamburg ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Glenn

(a) RESIDENCE. NO. 1624 W. Hamburg St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			19	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work ———

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Spencer Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Lillian Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Lillian Glenn
(Address) 164 W Hamburg St

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

JUL 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1921

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to July 29, 1921.

that I last saw her alive on July 27, 1921.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia & Influenza

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) As Premise

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death? 1624 W. Hamburg

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) John H. Traden, M. D.

. 19 (Address) 712 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 30 1921
20 UNDERTAKER John H. Traden	ADDRESS 142 Albemarle St

mation should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 55741

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55741

CERTIFICATE OF DEATH.

79

REGISTERED NO 134956

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Ensor ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Schattner

(a) RESIDENCE NO. 809 S. Robinson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Schattner

6 DATE OF BIRTH (month, day, and year) Aug-15-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
60	1360	14	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Lena Schattner

(Address) 809 S Robinson St

15 Filed Robert F. Harrison, Registrar

JL 30 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-20, 1921, to 7-29, 1921, that I last saw him alive on 7-29, 1921, and that death occurred, on the date stated above, at 4.50 P m.

The CAUSE OF DEATH* was as follows:

Asthma, Dropsy
Leakage of Heart

(duration) yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary) Leakage of Heart

(duration) yrs. 1 mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. G. McKennard, M. D.

, 19 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Greenmount — DATE OF BURIAL Aug 1st 1921

20 UNDERTAKER Peter Nicolaus — ADDRESS 2041 Eastern Ave

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55742

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 D 55742

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospt. ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Hannah Stephens

(a) RESIDENCE. NO. 1339 Mt Royal Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James Stephens

6 DATE OF BIRTH (month, day, and year) [illegible] 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant James Stephens
(Address) 1339 Mt Royal Ave

15 Filed . 19 Robert P. Harrison, Registrar

L 3 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7 1921, to July 28 1921, that I last saw her alive on July 28 1921, and that death occurred, on the date stated above, at 9:35 P m.

The CAUSE OF DEATH* was as follows:

Cardio-nephritis with hypertension (chr. nephritis).

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia, Bronchitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Dudley P. Bowe, M. D.

. 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Aug 2 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	827 N Howard St

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of c

Spec.—1-10-21—M&T—1500 Bks.

D 55743

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55743

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. Clinton ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred. Remlein

(a) RESIDENCE NO. 18 N. Clinton St. ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 8 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Sebastian Remlein

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Mauler

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Sebastian Remlein.
(Address) N. Clinton St.

15 Filed. Robert F. Harrison, 19
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1921

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1921, to July 28, 1921, that I last saw him alive on July 27, 1921, and that death occurred, on the date stated above, at 5.50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Illeo - Colitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John - G. Owens M. D.

(Address) Farmers Box + Store

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL July 30 1921

20 UNDERTAKER Lilly - Zeiler ADDRESS 403 S. Mott St

I. B. WARNING—Should be carefully supplied. AGE should be stated EXACTLY. Exact statement of mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be pr TION is very important. See instructions on back of ce

JL 3 1921

Spec.—1-10-21—M&T—1500 Bks.

D 55744 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55744

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 Lewis ST., 5 WARD)

REGISTERED No. 134956

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Myers

(a) RESIDENCE NO. 505 Lewis ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Richard Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Fanni Doney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City

14 Informant Sarah J. Frederick
(Address) 1223 Hanselman st

15 Filed JUL 30 1921 Robert P. Harrison, Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS should be careful and accurate. AGE should be carefully supplied. AGE and OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-28 1921

17

I HEREBY CERTIFY, That I attended deceased from 6-15-, 1921, to 7-28, 1921, that I last saw him alive on 7-28, 1921, and that death occurred, on the date stated above, at 10.35a. m.

The CAUSE OF DEATH* was as follows:

apoplexy contributed to heart

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Partial paralysis

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. G. W. Kennard M. D.

, 19 (Address) 708 Ensor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury — DATE OF BURIAL July 30 1921

20 UNDERTAKER John W Henderson — ADDRESS 1602 E Monument

Burial Permit Cleared

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55745 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55745

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William R. Barnes.

(a) RESIDENCE. NO. 2929 Guilford Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Barnes

6 DATE OF BIRTH (month, day, and year) Oct. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hanson Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER (illegible)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (illegible)

14 Informant W. Leigh Barnes

(Address) 2929 Guilford Ave

15 JL 30 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1921

17 I HEREBY CERTIFY, That I attended deceased from July 22 1921 to July 28 1921.

That I last saw him alive on July 28 1921.

and that death occurred, on the date stated above, at 4:35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration 6-7 yrs. mos. ds.)

CONTRIBUTORY (Secondary) Cardiac Decompensation (duration 11 Mo? yrs. 1 mos. ds.)

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) John J. Eyth M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park	Aug 1 1921

20 UNDERTAKER H. C. Wudefeld ADDRESS 914 Greenmount Ave

N. B.—WRITE PLAINLY with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. If less than one year or one day, the fraction should be properly classified. Exact statement of OCCUPATION of deceased may be important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55746

D 55746

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Hollins ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Alicia Carr

(a) RESIDENCE. NO. 1612 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Uriah A. Carr

6 DATE OF BIRTH (month, day, and year) Dec. 20-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER John O. Wall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Abigail Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs Ida Pickett 1612 Hollins St.

15 Filed JUL 30 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1921

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1921, to July 28, 1921.

that I last saw her alive on July 28, 1921.

and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Senility

(duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) R. Keller Hemmeter M. D.

7/30 1921 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL July 30 1921

20 UNDERTAKER George L. Schwab & Bro ADDRESS 201 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55747 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55747

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrews Hospitall ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs. Norah Hallins

(a) RESIDENCE. NO. 2014 Ashland Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Hollins March 1924

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67.	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wilkes Barre Co Mad

PARENTS

10 NAME OF FATHER Patrick Lynch.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Teresa Hollins (Address) 2014 Ashland Ave.

15 Filed JUL 30 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29th 1924

17 I HEREBY CERTIFY, That I attended deceased from 8 AM. 7-29. 1921. to 12 M 7-29 1921.

that I last saw her alive on 11 55 AM. 7-29. 1921.

and that death occurred, on the date stated above, at 11 55 A. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Sigmoid

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-29-24

Was there an autopsy? Yes.

What test confirmed diagnosis? Post mortem Exam

(Signed) Louis Sachs, M. D.

7-29. 1924 (Address) The Hebrew Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks bem	Aug 1st 1924
20 UNDERTAKER	ADDRESS
Geo M. Frist & Son	811 W Lafayette

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of Occupation should be properly classified. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55748

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55748

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Norman

(a) RESIDENCE. NO. 938 Leadenhall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thornton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant University Hospital records (Address)

15 Filed Robert P. Harrison, Registrar

JUL 30 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1921

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1921, to July 28, 1921, that I last saw her alive on July 28, 1921, and that death occurred, on the date stated above, at 8 25 A. m.

The CAUSE OF DEATH* was as follows: over

Acute pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Myocardial insufficiency Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Leslome

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert Lee, M. D.

7-28 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Albion Cemtery	July 31 1921

20 UNDERTAKER R. L. Parham ADDRESS 649 W. Lee St

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of
k of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Mitral Insufficiency primary.
Pregnancy.
Dr. Jone's conversation with Dr Reese.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

AUG 2 1921

WM. L. JORDEN
MANAGER

UNIVERSITY HOSPITAL
LOMBARD AND GREENE STREETS
BALTIMORE, MD.

Aug. 1 - 1921

Dr C. Hampson Jones
Hearst Bldg

In regard to the cause of death of Mabel Norman, I should like to advise you as follows:

She was admitted to the Hospital July 27th. At that time she had marked evidence of cardiac decompensation, with a marked mitral insufficiency, and a general anasarca. Urine examination was negative, and blood pressure was within normal limits.

She grew steadily worse after admission and died the following morning.

Hoping you can get your required data from the above short history.

Yours Sincerely
J Morris Lewis M.D.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D-55749

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

52D 55749

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 1219 Glyndon Ave ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mauritz

(a) RESIDENCE. No. 1219 Glyndon Ave ST., 21 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29. 1921.

7 AGE Years	Months	Days	If LESS than ~~1 day, hrs.~~ or 30 min.
	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Ferdinand Mauritz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kate Nimcick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ferd. Mauritz (Address) 1219 Glyndon Ave

15 Filed JUL 30 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1921, to July 29, 1921, that I last saw h im alive on July 29, 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Prolonged Labor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Transverse Position

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

7.29.21 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul bem: Woletteville DATE OF BURIAL July 30. 1921

20 UNDERTAKER C. W. Dill. ADDRESS 3109 Fredk. Rd.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55750 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55750

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Battery Av ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Schmidt

(a) RESIDENCE. No. 1508 Battery Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds How long in U. S., if of foreign birth? 40 yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schmidt

6 DATE OF BIRTH (month, day, and year) Apr. 25 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Schmidt (Address) 1508 Battery Ave.

15 Filed JUL 30 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 — 1921

17 I HEREBY CERTIFY, That I attended deceased from April - 2 — 1921, to July 28 1921, that I last saw h[illegible] alive on July 28, 1921, and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Heat - Exhaustion

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [illegible] M. D.

29/7/1921 (Address) 1258 Battery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	July 30 1921

20 UNDERTAKER ADDRESS

E J Fanning & Son 1460 Battery Ave

X. B.—[illegible] should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE TION is very important. See instructions on back of certificates.

D 55751 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55751

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 736 W. Franklin ST.: 19 WARD) REGISTERED No. C 150

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Augustus

(Residence in Baltimore: No. 736 W. Franklin St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, July 29, 1921
(Month) (Day) (Year)

7-AGE, ...yrs....mos. 1 ds. If LESS than 1 day, 2 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....none
(b) General nature of industry, business, or establishment in which employed (or employer).....(Infant)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Bernard Bailey

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Evelina Augustus

13-BIRTHPLACE OF MOTHER (State or Country), 736 W. Franklin

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evelina Augustus

(Address) 736 W. Franklin St

15- Robert P. Harrison,

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 29, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(Duration).....yrs.....mos. 1 ds.

CONTRIBUTORY (Secondary).....(Duration).....yrs.....mos.....ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

July 30, 1921 (Address) 2802 E. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Carmel	July 29, 1921
20-UNDERTAKER	ADDRESS
Daniel Easter	Penn

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UH 30 1921 Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D 55752 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55752

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 Penn Ave ST.; 17 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Thomas

(Residence in Baltimore: No. 416 Penn Ave St.; 51 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, not definite (Month) (Day) 1870 (Year)

7-AGE, ... yrs. 51 mos. ..... ds.

If LESS than 1 day, ~~hrs. or~~ min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Wood Worker

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Not-Known

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Easton

(Address) 916 Penn Ave

15-

Filed ..... 1921 Robert P. Harrison, Registrar.

JUL 30 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 29 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1921 to July 29 1921, that I saw him alive on July 29 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) 6 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchitis Chronic

(Duration) 20 yrs. mos. ds.

(Signed) R. B. Mc[illegible] M. D.

7/30, 1921 (Address) 609 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, August, 1921

20-UNDERTAKER David Easton

ADDRESS 916

R.—Every item of information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55753

D 55753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 W 27 ST.: 12 WARD)

2-FULL NAME Eileen B. McLaughlin

(a) RESIDENCE. No. 212 W 27 ST., 12 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. 10 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13-1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph M'Laughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Sadie Whelan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Joseph M'Laughlin
(Address) Robert P. Harrison

15 Filed ..... 19 ..... Registrar
Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM should be stated EXACTLY. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-30 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-10 1921, to 7-30 1921, that I last saw h[illegible] alive on 7-29 1921, and that death occurred, on the date stated above, at 12 05 a.m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Acute Enteritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical symptoms

(Signed) C. F. Craigheit, M. D.

7-30 1921 (Address) 3701 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	July 31 1921

20 UNDERTAKER E. Hobson ADDRESS 848 N. Howard St.

D 55754 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55754

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 649 Hanover st 21 '79 REGISTERED NO. C

CITY OF BALTIMORE (No. ~~Thomas A. Goldman~~ and ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas A Goldman

(Residence in Baltimore: No. 649 Hanover St St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... Don't Know, 1 .....
(Month) (Day) (Year)

7-AGE, ... 3J ~ yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... D4

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), (,)

12-MAIDEN NAME OF MOTHER (,)

13-BIRTHPLACE OF MOTHER (State or Country), ( )

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Florence Denton

(Address) 649 Hanover St

15-

Filed ..... Robert P. Harrison, M.D. Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July ..... 28 ..., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ topsy or inquiry.) found that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

7-29..., 1921 (Address) 117 W Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, 7-30, 1921

20-UNDERTAKER Jno A Gott & Son

ADDRESS 406 N Eutaw St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

GL 3 6192

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55753 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55755

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Wagner

(a) RESIDENCE. NO. 217 E. Montgomery ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 30, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wilhasie Wagner

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Weber

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant University Hospital
(Address)

15 Filed 19 Robert P. Harrison, Registrar

JUL 30 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1921, to July 30, 1921, that I last saw him alive on July 29, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Intestinal decomposition

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Brest Pain, Left arm

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? 217 E. Montgomery St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs symptoms

(Signed) R. B. Jones, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel M E Church Cemetery Odenton DATE OF BURIAL July 31 1921

20 UNDERTAKER John F Denning. ADDRESS 715 Light St

U. S.—WRITE plainly. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

55756 D 55756

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 120 ✓ D 55756

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J Fewes

(a) RESIDENCE NO. Fort Howard Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25 - 1881

7 AGE 40 Years 6 Months 5 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician 029

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Fewes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Dorothy Solomon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital. Record.

15 Filed JUL 31 1921 ROBERT J KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29-1921

17

I HEREBY CERTIFY, That I attended deceased from July 29-1921. to July 29-1921. that I last saw her alive on July 29-1921, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Uremia Chronic Nephritis

Said to be
(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency
(duration) approximately yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Fort Howard, Md.

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Blood Chemistry

(Signed) U. R. Mason M. D.

7-30-21 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 8/2 1921

20 UNDERTAKER Henry W. Moss & Son

ADDRESS 1054 N. Calvert St.

N. B.—WRITE LEGIBLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be p TION is very important. See instructions on back of c

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55757 D 55757

CERTIFICATE OF DEATH.

64 D 55757

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Mount Hope Retreat ST.: 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Finnegan

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? not known yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs Finnegan

6 DATE OF BIRTH (month, day, and year) Not Known.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Not Known abt	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laboring -

(c) Name of employer not known

9 BIRTHPLACE (city or town) not known
(State or country) Ireland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland -

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md.

15 Filed JUL 31 1921 ROBERT A. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3rd, 1921, to July 30, 1921, that I last saw h(im) alive on July 30, 1921, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis - Post Cerebral Hemorrhage - abt 3 Wks

(duration) 0 yrs. 0 mos. 27 ds.

CONTRIBUTORY (Secondary) Senile Dementia over (duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

July 30, 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loreat Hoor	July 30 1921
20 UNDERTAKER Wm. Mc Fink	ADDRESS 1836 N. Rolly

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55758 | 151 D 55758

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 11 WARD)

2-FULL NAME Mary Sawyer

(a) RESIDENCE NO. 949 N. Caton St. 11 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18-1921

7 AGE Years 3 Months 22 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lloyd Sawyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Hattie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Record

15 Filed JUL 31 1921 ROBERT I. GAITHER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to July 30, 1921.

that I last saw he alive on July 30, 1921.

and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) Wilbanks, M. D.

19 (Address) Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: July 31 21

20 UNDERTAKER: George H. Holland — ADDRESS: 1631 Homestead

N. B.—WRITE PLAINLY, with ink or indelible pencil. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1090 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55759

CERTIFICATE OF DEATH.

X 78 D 55759

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny Arnold

(a) RESIDENCE. NO. Westminster, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	17	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Reisterstown Carroll Co. Md.

PARENTS

10 NAME OF FATHER Emmanuel Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westminster Md.

12 MAIDEN NAME OF MOTHER Jennie Rand.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Vernon Arnold (Brother)
(Address) Westminster Md.

15 Filed JUL 31 1921 ..., 19... ROBERT P. ... Registrar
Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to July 30, 1921, that I last saw h.er alive on July 30, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Chorea -

(duration) ... yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Westminster, Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none -

(Signed) W. B. Jones, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Md

DATE OF BURIAL: Aug 2 19...

20 UNDERTAKER: W. M. Ronteon

ADDRESS: 2 S. ... Milton

N.B.—WHITE BLANKS ONLY. PRINTED MATTER should be stated EXACTLY. Physician's diagnosis should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55760

CERTIFICATE OF DEATH.

1920 D 55760

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3801 Clifton Ave. St.: 15th WARD)

2-FULL NAME Annie M. Appleby.

(a) RESIDENCE. No. 3801 Clifton Ave. St., 15 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs 5 mos 27 ds. How long in U. S., if of foreign birth? yrs mos ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward H. Appleby

6 DATE OF BIRTH (month, day, and year): Feb. 2 - 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Lamb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Charlotte McCormack

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Wm. H. Appleby
(Address) 3833 Roland Ave.

15 Filed JUL 31 1921 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1920, to July 29, 1921, that I last saw h[illegible] alive on July 28, 1921, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis - myocarditis
Interstitial nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Uremia - chronic interstitial nephritis - myocarditis - arterio sclerosis)

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical

(Signed) W. S. Nibley M. D.

July 29 1921 (Address) 2220 Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug. 1 1921

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 363 Falls Rd.

N. B.—THESE BLANKS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55761

CERTIFICATE OF DEATH.

167 D 55761

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 702 W. 34 St, St 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellmer F. Harper

(Residence in Baltimore: No. 702 W. 34 St, St.: 2 yrs., 2 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Single

6-DATE OF BIRTH: May 17, 1919 (Month) (Day) (Year)

7-AGE: 2 yrs. 2 mos. 12 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore, Md

PARENTS.

10-NAME OF FATHER: Elmer Harper

11-BIRTHPLACE OF FATHER (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: L. Dola Shaffer

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer Harper

(Address) 702 W. 34th St.

15- [illegible] R KRAUTZ

Filed JUL 31 1921 191 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July 29, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Coroner, autopsy or inquiry.) and that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Burns Accidental 4

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Shock,

(Duration) .... yrs. .... mos. .... ds.

(Signed) G. C. Wades M. D. (Coroner)

7/30/1921 (Address) 443 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: Aug. 1, 1921

20-UNDERTAKER: Horace H. Burgee — ADDRESS: 3631 Falls Rd.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Edwin G. Stiles' Widow caught a fish

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 | D 55762

D 55762

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 N. Hilton St.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia. F. Schlueter

(a) RESIDENCE. NO. 310 N. Hilton St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry. C. Schlueter

6 DATE OF BIRTH (month, day, and year) June 5 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Schmaltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Dust Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Henry. C. Schlueter 310 N. Hilton St.

15 Filed JUL 31 1921 BOWEN & KRAUTH Registrar Racial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20 1921 to July 28 1921 that I last saw her alive on July 28 1921 and that death occurred, on the date stated above, at 11.23 m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis [illegible]

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Wm Love M. D.

19 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 6 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2173 Pa. Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage. No further history

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55763

CERTIFICATE OF DEATH

37

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No..... ST.: 14 WARD)

2-FULL NAME Frank Johnston

(a) RESIDENCE. No. 1842 Druid Hill Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Alice J Johnston

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bell-Hop.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Thompson (Address) 1200 Eutaw St

15 AUG 1 - 1921 [illegible] Registrar

Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 13, 19 20 to July 28, 19 21, that I last saw h[illegible] alive on July 28 19 21 and that death occurred, on the date stated above, at 430 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lues Cerebrum

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) H. Goldsmith M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hope Cemetery	AUG 1 5, 192[illegible]
20 UNDERTAKER	ADDRESS
Edw. Ruggold	1463 N Carey

Mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55764 ✓91 104 D 55764

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.: N1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Declora

(a) RESIDENCE. NO. 1174 Sargent ST., WARD. Chelsea

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Febry 19th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Declora

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Caroline Seasino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mr. John Declora (Address) 1174 Sargent St.

15 AUG 1 - 1921 [illegible] Registrar

Serial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1921, to July 29, 1921, that I last saw her alive on July 29, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia

Gastro Enteritis

Unknown (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

(Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cemetery	July 31st 1921
20 UNDERTAKER John Howard & Son	ADDRESS 90 Holliday St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55765

CERTIFICATE OF DEATH.

79 D 55765

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2600 E. Hoffman ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M. Graw

(a) RESIDENCE NO. 2600 E. Hoffman ST., 8 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Graw

6 DATE OF BIRTH (month, day, and year) Nov. 15-1857.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Feller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Graw (Address) 2600 E. Hoffman St.

15 Filed AUG 1 - 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1919 to July 28, 1921, that I last saw h[illegible] alive on July 26, 1921, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Hypocardia

(duration) 2 yrs. 6 mos 13 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

7/29 1921 (Address) 1823 N. Wash St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Aug 1 1921

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

14967 D 55766

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55766

X 104

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Gray

(a) RESIDENCE No. Sycamore Ave East Baltimore WARD (Balto Co.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Major Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Olivia Woodstead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Johns Hopkins Hospital Records

15 AUG 1 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27- 1921

17 I HEREBY CERTIFY, That I attended deceased from July 23 - 1921 to July 27 - 1921 that I last saw her alive on July 27 - 1921 and that death occurred, on the date stated above, at 8 20 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea not dysentery

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) W Davies M. D.

(Address) 4 H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulany Cemetery

DATE OF BURIAL 8/1/21 19

20 UNDERTAKER Sam W. Chase

ADDRESS 1400. Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55767

CERTIFICATE OF DEATH.

91-1N4 V D 55767

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 S Fulton Ave ST., 19 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Presley Patterson

(a) RESIDENCE NO. 17 S. Fulton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Alice Patterson

6 DATE OF BIRTH (month, day, and year) 7-4-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76 -	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dispatcher 073

(b) General nature of industry, business, or establishment in which employed (or employer) United Ry + El. Co.

(c) Name of employer United Ry + Elec Co

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Wm Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Adaline Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Alice Patterson
(Address) 17 S. Fulton ave

15 Filed AUG 1 - 1921 ROBERT I. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 19 21, to July 29, 19 21,
that I last saw h[illegible] alive on July 28, 19 21,
and that death occurred, on the date stated above, at 10. a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) Several yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) G B Burton, M. D.

(Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL AUG 1 - 1921

20 UNDERTAKER W J Sikes & Son — ADDRESS Penna & Santa Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55768 ✓ D 55768

104

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 Leslie ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dolores Gaither

(Residence in Baltimore: No. 1529 Leslie st - St.; ..yrs., 6 mos. 4 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Baby

6-DATE OF BIRTH. Dec 22th, 1920 (Month) (Day) (Year)

7-AGE. ..yrs. 6 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wilson Sewell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Belle Gaither

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Gaither

(Address) 1529 Leslie st

15-

Filed AUG 1 - 1921, 191.....

ROBERT J. KRAUTH
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30th, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17th 1921, to July 30 1921, that I saw h- alive on July 28 1921, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Acute Fulminating Colitis

(Duration) ..yrs. ..mos. 15 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..yrs. ..mos. ..ds.

(Signed) Harry J. Brown M. D.

July 30 1921 (Address) 15 01 Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Mt Auburn AUG 1 - 1921

20-UNDERTAKER ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST

D 55769

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55769

CERTIFICATE OF DEATH.

REGISTERED No. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1840 Pennsylvania Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah F. Hall

(Residence in Baltimore: No. 1840 Pennsylvania Ave St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	colored	single

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1874 (Year)

7-AGE,	If LESS than 1 day,
47 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Wesley Hall

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Alice Handy

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel J. Hall

(Address) 1548 Pennsylvania Ave.

15- AUG 1 - 1921 ROBERT B KRAUTH

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Organic heart disease

..... (Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. D. Hennessy M. D.
(Coroner.)

July 30, 1921 (Address) 1502 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, West ave & Mt. Olivet DATE OF BURIAL, Aug 1, 1921

20-UNDERTAKER JAMES H. DENNIS & SON ADDRESS 1505 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Pamphlet

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55770

CERTIFICATE OF DEATH.

29 ✓ D 55770

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 South St.; 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Pamplin

(Residence in Baltimore: No. 644 South St.; 8 yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1890
(Month) (Day) (Year)

7-AGE, 31 yrs. .... mos. .... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Montgomery Co Md

PARENTS.

10-NAME OF FATHER, John Claggett

11-BIRTHPLACE OF FATHER (State or Country), Montgomery Co. Md

12-MAIDEN NAME OF MOTHER Amelia Campbell

13-BIRTHPLACE OF MOTHER (State or Country), Montgomery Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Pamplin

(Address) 644 South St.

15- Filed AUG 1 - 1921, 191.... ROBERT I. KRAUTZ Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 8 1921, to July 30 1921, that I saw h[er] alive on July 30 1921, and that death occurred, on the date stated above, at 1.40 p.m.

The CAUSE OF DEATH* was as follows:

Pthisis Florida

(Duration) .... yrs. 1 mos. .... ds.

CONTRIBUTORY (Secondary) .....

(Duration) .... yrs. .... mos. .... ds.

(Signed) T. E. Slaughter M. D.

....., 191... (Address) 1602 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cem. | DATE OF BURIAL, Aug 1, 1921

20-UNDERTAKER James L. Davis | ADDRESS 1303 Pulaski

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D55771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D55771

CERTIFICATE OF DEATH.

64 12779 a

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1316 E Lafayette St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Mason

(a) RESIDENCE. NO. 1316 E Lafayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs mos ds. How long in U. S., if of foreign birth? 40 yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ Rose Mason

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE: Years 64; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oiler 04

(b) General nature of industry, business, or establishment in which employed (or employer): M. Loyd Shipping State

(c) Name of employer: City of Balto.

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs M. Dynn 1316 E. Lafayette ave

15 Filed AUG 1 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1921 to July 29, 1921, that I last saw him alive on July 29, 1921, and that death occurred, on the date stated above, at 5.35 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George E. Dayton, M. D.

, 19 (Address) 1617 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery Harford Road	Aug 2. 21
20 UNDERTAKER	ADDRESS
George F. Ruth	1735 Harford Ave.

Burial Permit Oiler

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55772

D 55772

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2813- Hudson ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget A. Magee

(a) RESIDENCE. No. 2813- Hudson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs — mos — ds. How long in U. S., if of foreign birth? 74 yrs — mos — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Thomas J. Magee

6 DATE OF BIRTH (month, day, and year): 7/5/1842

7 AGE — Years: 79 — Months: — — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thomas Larken

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Jane Hogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Jane A. Magee
(Address) 2813- Hudson St

15 Filed AUG 1 - 1921 FOREST J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1921

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1921, to July 29, 1921, that I last saw h[illegible] alive on July 28, 1921, and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): myocarditis
(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/30, 1921 (Address) 829 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cath. Cem. — DATE OF BURIAL: 8/1/21 19

20 UNDERTAKER: Geo. J. Pentz — ADDRESS: 1135 Hanford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Burhans

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55773

CERTIFICATE OF DEATH.

109 D 55773

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital St.; No (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Burhans

(a) RESIDENCE. NO. 309 S. Second ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Burhans

6 DATE OF BIRTH (month, day, and year) — 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
25				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coke Oven Workman

(b) General nature of Industry, business, or establishment in which employed (or employer) 186

(c) Name of employer Maryland Steel Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry Burhans

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Martin

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs E. Burhans (Address) 309 S. Second st.

15 Filed AUG 1 - 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1921 to July 31, 1921 that I last saw him alive on July 31, 1921, and that death occurred, on the date stated above, at 1.20 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

General peritonitis

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 31, 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W J Jones, M. D.

July 31, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery.	Aug 3 1921
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55774

CERTIFICATE OF DEATH.

X 74 ✓

D 55774

1-PLACE OF DEATH US. Public Health Hosp. #56

REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST., WARD) 114

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Demetrius Simon

(a) RESIDENCE NO. US. public Health Hosp. #56 ST., Fort McHenry WARD Baltimore Md.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
44	yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 186

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar
(Address) US PHS Hosp. #56 Ft McHenry Md.

15 Filed AUG 1 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 14, 1921 to July 28, 1921.

that I last saw him alive on July 28, 1921,

and that death occurred, on the date stated above, at 7'18 a. m.

The CAUSE OF DEATH* was as follows:

Hernia of Brain

Jan. 14 /21 (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Hernia of Brain

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas R. Payne M. D.

, 19 (Address) Senior Surgeon (R) US. PHS Hosp. #56 Ft McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL July 1921

20 UNDERTAKER J Lemmon & Bro Baltimore — ADDRESS (117)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55775

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55775

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Tomlinson

(a) RESIDENCE. No. Park Heights & 7 Mile Lane WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea Captain

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Tomlinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Bridges

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Mrs Minton W Bernard Park Heights 7 Mile Lane

15 Filed AUG 1 - 1921 19 ROBERT J. BRAUTIGAM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10 . 1921 . to July 31 . 1921 .

that I last saw him alive on July 31 . 1921 .

and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis Toxemia 1 month

Cerebral thrombosis 3 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sugar Symptoms

(Signed) John L Byron M. D.

. 19 (Address) Emergency Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Urbanna Va	Aug 2 21
20 UNDERTAKER Un Cook	ADDRESS 502 E Va Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Blade Fayette & Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55776

CERTIFICATE OF DEATH.

18 V D 55776

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 715 Street E Eastern 1ST. Ave 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie H- Mason

(Residence in Baltimore: No. 3025 Frederick Road St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH. April 19, 1895
(Month) (Day) (Year)

7-AGE. 16 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... 09

9-BIRTHPLACE, (State or Country) Baltimor Maryland

PARENTS.

10-NAME OF FATHER. John H. White

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER. Iona Lee

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. White

(Address) River View Terrace (Colgate)

15-

Filed ..... 1911. ROBERT J. BRAUTER 191.....
(Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH July 29- 1911.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot wounds; Homicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Claude Blades M. D.
(Coroner)

7/30/11 (Address) 1436 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Oaklawn

DATE OF BURIAL. July 29 1911

20-UNDERTAKER William Cook

ADDRESS 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE BURIAL, WITH CREMATION OR REMOVAL PERMIT RECORD

Remarks

Listed in hands of Frank Heffron
P.R.R.Co. Track walker.
of Said Case
4 Aldrich —

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage*,	*Meningitis*,	*Phlebitis*,
Cellulitis,	*Gangrene*,	*Miscarriage*,	*Pyæmia*,
Childbirth,	*Gastritis*,	*Necrosis*,	*Septicæmia*,
Convulsions,	*Erysipelas*,	*Peritonitis*,	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

D 55777 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55777

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 16 Albermarle St. 3rd Floor, Rear 104 St.; 3 WARD)
(If death occurred in a hospital or Institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angelina Sophia

(Residence in Baltimore: No. 16 Albermarle St 3rd Floor Rear St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F.	White	Single

6-DATE OF BIRTH. ....., 1..... (Month) (Day) (Year)

7-AGE. .....yrs. 6 mos. .....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — Child
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.
10-NAME OF FATHER, John Sophia
11-BIRTHPLACE OF FATHER (State or Country), Italy
12-MAIDEN NAME OF MOTHER Carmella Pippitone
13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Sophia
(Address) 16 Albermarle

15- AUG 1 - 1921 ....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Jos. L. Wade M. D.
(Coroner.)
July 31 1921 (Address) 143 N. Gray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross	Aug 1, 1921
20-UNDERTAKER Wm. Cox	ADDRESS 50 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks: [illegible] Supplemental Certificate
to Child to be Buried by city.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55778

D 55778

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tbc Hosp. ST.: WARD 1

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas O'Laughlin

(a) RESIDENCE. NO. 737 S. Curley ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wh	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23rd 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 056

(b) General nature of industry, business, or establishment in which employed (or employer) Jelly Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Martin O'Laughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ella Mansfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records (Address)

15 Filed AUG 1 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 29th 1921, to July 30 1921, that I last saw him alive on July 30 1921, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) 3 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Alfred O'Neill M. D.

, 19 (Address) Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cemetery	Aug 2 1921
20 UNDERTAKER William Cook	ADDRESS 502 E North

N. B.—WRITE ... mation s... CAUSE OF DEA... TION is very important. See instructions on back of certificates. ... statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 55779

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. WARD 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel J. Kurtz

(a) RESIDENCE. No. 3011 Prestman st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steel worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Sam'l. Kurtz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Anne C. Gorman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records

(Address) N. T. H. [illegible]

15 Filed AUG 1 1921 19 [illegible] Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1918, to July 30, 1921, that I last saw him alive on July 30, 1921, and that death occurred, on the date stated above, at 1.35 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Clyde Mowell, M. D.

7-30-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 2 1921
20 UNDERTAKER	ADDRESS
Wellman Cook	502 E Nor

N. B.—W... CAUSE OF DEATH ... TION is very important. See instructions on back

Spec.—1-10-21 M&T 1500 Bks.

D 55780 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55780

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 N Luzerne St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Straysbaugh

(a) RESIDENCE NO. 904 N Luzerne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Straysbaugh

6 DATE OF BIRTH (month, day, and year) June 14-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	37	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edgar Brawn

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant John Straysbaugh

(Address) 904 N. Luzerne Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 19 24

17 I HEREBY CERTIFY, That I attended deceased from July 20, 19 24, to July 30 19 24.

That I last saw he alive on July 28, 19 24.

and that death occurred, on the date stated above, at 9 00 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

July 30, 1924 Address 900 N Luzerne Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Aug 2 1924

20 UNDERTAKER William Cook — ADDRESS 501 E Nash

N.B.—Your attention is called to the fact that a full and complete answer to every question on this certificate is required by law. Any omission or error will delay burial. In case of DEATH from any CAUSE OF DEATH in plain terms, stating the disease causing death, or in deaths from violent causes, the means and nature of injury should be stated. Every CERTIFICATE OF DEATH is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55781 61 D 55781

CERTIFICATE OF DEATH.

REGISTERED NO.

D 55781

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Fait ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude M Siebert

(a) RESIDENCE. NO. 2408 Fait ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs mos ds How long in U. S., if of foreign birth? 21 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	4	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm H Siebert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER B. C. Siebert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant B. C. Siebert
(Address) 2408 Fait Ave

15 Filed JUL - 1921 19 ROBERT A. BRUCE Registrar
Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29 1921, to July 31 1921, that I last saw him alive on July 31 1921, and that death occurred, on the date stated above, at 5-18 P. M.

The CAUSE OF DEATH* was as follows:

Meningitis 3 ds.
(Duration) yrs. mos.

CONTRIBUTORY (Secondary) Convulsions
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. S. Green M. D.

7/3/21 (Address) 408 S Port Pl Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Aug 2 19

20 UNDERTAKER ADDRESS
W. M. Cook 502 E Madison

mation should be given in plain terms, so that it may be clear what is the CAUSE OF DEATH in plain terms, so that it may be clear what is the CAUSE OF DEATH in plain terms, so that it may be clear what is the CAUSE OF DEATH

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Simple meningitis.
Phy. states only abnormal condition was child had dislocated arm but ~~he does~~ had nothing to do with child's death.

6-9-19—H. P. Co.—1000 Blks.

D 55782 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55782

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH 2204 Oak St.

CITY OF BALTIMORE: No. 2204 Oak St. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Gaines

(a) RESIDENCE NO. 2204 Oak ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~~Single~~ Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 17-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER William Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Catherine Slattery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City

14 Informant Katherine Gaines

(Address) 2204 Oak St. City

15 Filed ... 19... REGISTRAR ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31. 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30. 1921. to July 31. 1921.

that I last saw him alive on July 31. 1921.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 2204 Oak St.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Urine + Stool

(Signed) W. H. Engman M. D.

, 19 (Address) 2429 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W/X Carmel	Aug 1/21
20 UNDERTAKER Wm. Cook	ADDRESS 503 N. Wolfe

CAUSE OF DEATH. See instructions on reverse side. ATTENTION is very important.

Dec.—6-9-19—H. P. Co.—1000 Bks.

D 55783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 55783

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3003 Rosedale ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Zachariah Carter Forsyth

(a) RESIDENCE. NO. 3003 Rosedale ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Eagers

6 DATE OF BIRTH (month, day, and year) Jan 17-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59 —			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Knitted Machine Shop

(c) Name of employer Cuba Yard

9 BIRTHPLACE (city or town) (State or country) Cuba

PARENTS

10 NAME OF FATHER Zachariah

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Holton

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Henry C. Forsyth (Address) Same

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1920, to July 31, 1921, that I last saw h[illegible] alive on July 30, 1921, and that death occurred, on the date stated above, at 12.55 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin G. Mayer M. D.

7/31 1921 (Address) 2438 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Aug 3 1921

20 UNDERTAKER Guy Cook

ADDRESS 502 E North

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1495 83 55784 — D 55784

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry

(a) RESIDENCE NO. 1603 E. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) live in Balt- 50 years
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Henry

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Henry

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Md

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed 1921 Registrar

CAUSE OF DEATH IN [illegible] TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1921

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to July 28, 1921, that I last saw him alive on July 28, 1921, and that death occurred, on the date stated above, at 3:25 P. m.

The CAUSE OF DEATH* was as follows:

(2) Intestinal Obstruction.
(1) General Peritonitis.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Peritonitis (general)

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of July 25 1921

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy + operation

(Signed) Jay McKeen, M. D.

7-25-21 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Aug 1 1921

20 UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55785

CERTIFICATE OF DEATH.

150 D 55785

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Jackson ST.; No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Clark

(a) RESIDENCE. No. 1424 Jackson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): July 29-1921

7 AGE: Years Months Days (33 hrs) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Arthur Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Rachel Glass

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Arthur Clark
(Address): 1424 Jackson

15 Filed — 1921 Registrar

CAUSE OF DEATH. TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1921, to July 30, 1921, that I last saw him alive on 7.30, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

(Pneumococcic Meningitis)
(Sunken Fontanelle)

(duration) yrs. mos. 33 ds.

CONTRIBUTORY (Secondary): Gen Debility

(duration) yrs. mos. 33 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Burlington, M. D.

, 19 (Address) 102 E Fortune

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 8/ 1921

20 UNDERTAKER: J. Fred McCully

ADDRESS: 130 E. Fay

Dec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55786

CERTIFICATE OF DEATH.

144 D 55786

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Aaron

(a) RESIDENCE. NO. 428 N. Stricker St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	N.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Bertha Aaron.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65 yrs.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Khypsie Cluke.

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Mrs. Bertha Aaron.

(Address) 428 N. Stricker St

15 Filed 1921 Registrar

CAUSES OF DEATH. See INSTRUCTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31 1921

17

I HEREBY CERTIFY, That I attended deceased from 7-30, 1921, to 7-31, 1921, that I last saw him alive on 7-31, 1921, and that death occurred, on the date stated above, at 4 25 A.m.

The CAUSE OF DEATH* was as follows:

Multiple abscesses chin mouth.

OVER

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Septicaemia (streptococcus

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 7-30-21.

Was there an autopsy? No.

What test confirmed diagnosis? Bacteriological

(Signed) Dudley P. Bowden, M. D.

, 19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harsinia	Aug 1 1921

20 UNDERTAKER J. Ahrens & Co ADDRESS 1611 Mad ave

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Source of infection unknown. Probably due to oral sepsis.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55787

CERTIFICATE OF DEATH.

40

D 55787

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Hanover ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah M. Simon

(Residence in Baltimore: No. 1518 S. Hanover St.; 66 yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH, July 29 (Month) (Day), 1855 (Year)

7-AGE, 66 yrs. mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank Adelsheimer

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER A. M. Norton

13-BIRTHPLACE OF MOTHER (State or Country), Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Rummel

(Address) 1518 Hanover St.

15. AUG 1 - 1921 Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 20 1921, to July 30 1921, that I saw h[illegible] alive on July 29 1921, and that death occurred, on the date stated above, at 3.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

and Pyelitis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cystoscopic treatment

(Duration) yrs. mos. 2 ds.

(Signed) L. M. Zimmerman M. D.

July 31, 1921. (Address) 826 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Farmer or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount | DATE OF BURIAL, Aug 2, 1921

20-UNDERTAKER J. AHRENS & CO. ADDRESS 611 MADISON AVENUE.

FUNERAL DIRECTORS AND EMBALMERS

- important. See instructions on back.

Burial Permit Clerk

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55788 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55788

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 428 S Broadway ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wong Fay

(a) RESIDENCE. NO. 428 S Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Chinese	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 9 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER Wong Wah

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Lee Yee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant Wong Sam

(Address) 2272 O'Donnell St

15 Filed AUG 1 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28 1921, to July 30 1921, that I last saw him alive on July 30 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Malnutrition

(duration) yrs. 6 mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard M. D.

(Address) 4 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Aug 1 1921
20 UNDERTAKER John C. Mitchell	ADDRESS 121 W Fayette

N. B.—WRITE PLAINLY. All items must be carefully supplied. Age should be given in years, months and days. Information should be carefully supplied, so that it may be properly classified. Each CAUSE OF DEATH in plain terms, so that it may be properly classified. Each CAUSE OF DEATH should be given

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 D 55789

CERTIFICATE OF DEATH.

D 55789

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N. Wolfe ST., 6 WARD)

2-FULL NAME Joseph Schwartz

(a) RESIDENCE NO. 212 N. Wolfe St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Schwartz

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Goodman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1411. E. Baltst

15 Filed AUG 1 - 1921, 19 ..... Registrar

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1921, to July 31, 1921, that I last saw him alive on July 31, 1921, and that death occurred, on the date stated above, at 11¼ m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) chronic yrs. mos. ds.

CONTRIBUTORY (Secondary) chronic Nephritis

(duration) chronic yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Meyer Ephraim M. D.

7/31, 1921 (Address) 1904 E Balt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL Aug 1 1921

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E Balt st

CAUSE OF DEATH IS very important. See instructions on

Dec.—6-9-19—H. P. Co.—1000 Bks.

Leona M. Buckler

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 ✓ D 55790

CERTIFICATE OF DEATH.

D 55790

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 James ST.: 21 WARD)

2-FULL NAME Leona Moore Buckler

(a) RESIDENCE. NO. 1319 James ST., 21 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 7 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 23/21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	7	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Julius F Buckler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware.

14 Informant John F Buckler
(Address) 1319 James St

15 Filed AUG 1 - 1921 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to July 31, 1921, that I last saw h[illegible] alive on July 31, 1921, 5:30 m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Acute Ilio. Colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acidosis — (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Edward Woolahan, M. D.

19 (Address) 24 N Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Aug 1 19[illegible]
20 UNDERTAKER	ADDRESS
Mrs J E Evans & Sons	1425 St Charles Av

TION is very important. See instruction

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55791

D 55791

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 Guilford Ave., ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Cecilia M. Welsh

(a) RESIDENCE. NO. 301 Guilford Ave, ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. -- mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 22, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Martin Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Kehoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Martin Welsh

(Address) 301 Guilford Ave.

15 Filed AUG 1 1921 [illegible] Registrar

Burial Permit Issued

CAUSE OF DEATH. See instructions on reverse side. IMPORTANT. INFORMATION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to July 30, 1921, that I last saw h[illegible] alive on July 30, 1921, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Infectious Pneumonia

of (duration) . yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

2 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. F. Ruby, M. D.

, 19 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery 8/	1/21 19

20 UNDERTAKER Henry W. Mears & Son, ADDRESS 805 Calvert St.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55792

CERTIFICATE OF DEATH.

1919 50 92-869 D 55792

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 822 N Paniel St ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Brafford

(a) RESIDENCE NO. 822 N Paniel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1869.

7 AGE	Years	Months	Days	If less than 1 day, hrs. or min.
	50	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Mike Brafford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Coral Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Mrs Amy Brafford 822 N Paniel St

15 Filed AUG 1 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18th, 1921, to July 29th, 1921, that I last saw him alive on July 29th, 1921, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia (duration) 2 yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Angina Pectoris (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? 822 N Paniel St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W C Cather M. D.

. 19 (Address) 1063 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Aug 3 1921

20 UNDERTAKER Thomas E Wright ADDRESS 1369 Carey

CAUSE OF DEATH. See instructions on reverse side. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55793

CERTIFICATE OF DEATH.

104

D 55793

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 Riverside ave ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Beiulin

(a) RESIDENCE NO. 1220 Riverside av ST., WARD 24

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 17 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John A Beiulin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ella Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) John A Beiulin 1220 Riverside ave

15 AUG 1 - 1921 (Date) [illegible] KREUTER Registrar

CAUSE OF DEATH in plain ... TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/30 1921

17 I HEREBY CERTIFY, That I attended deceased from 7/20/21, 19..., to 7/30, 1921, that I last saw him alive on 7/30/21, 19..., and that death occurred, on the date stated above, at 9 8 m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis acute

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) dilated heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Diarrhea vomiting

(Signed) Jas [illegible] O'Donnell, M. D.

7/30, 1921 (Address) 1015 Mulb

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	8-1 1921
20 UNDERTAKER	ADDRESS
E & B Hale	115 E Lexington

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 55794

D 55794

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 Harlem ave WARD 6)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Murray Drury

(a) RESIDENCE. No 1133 Harlem ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married, widowed~~, or divorced HUSBAND of (or) WIFE of James Poole Drury

6 DATE OF BIRTH (month, day, and year) Oct. 11-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis A. Thomas

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah E Hair

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant Helen V. Drury
(Address) 1133 Harlem ave

15 Filed AUG 1 - 19 , 19 COLEMAN & KRAUTER Registrar
Burial Permit Dlvd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10 th. 1921. to July 30 th 21.
that I last saw h[illegible] alive on July 30 th 1921.
and that death occurred, on the date stated above, at 1010 a m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) 1 yrs. X mos. 20 ds.

CONTRIBUTORY (Secondary) 1 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) V. Allen Williams, M. D.

, 19 (Address) 601 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	8/2/21, 19
20 UNDERTAKER John B Spencer	ADDRESS 1525 N. Caroline

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55795

CERTIFICATE OF DEATH

D 55795

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 St Fremont ST.; 16 WARD)

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate T. Alcock

(a) RESIDENCE NO. 622 St Fremont ST., 16 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word): Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: John D. Alcock

6 DATE OF BIRTH (month, day, and year): Jan 11, 1834

7 AGE — Years: 87 — Months: 6 — Days: 20 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone cod

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Uniontown Carroll Co Md

PARENTS

10 NAME OF FATHER: Nathaniel R. Hendrickson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eliza Botsford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Stat SK. Alcock 622 St Fremont Ave

15 Filed 19 [illegible] Registrar

CAUSE OF DEATH. INFORMATION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 9 1921 to July 30 1921 that I last saw h~~er~~ alive on July 30 1921 and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Heart prostration

(duration) 3 yrs. mos. 2 2 ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bernard Purcell Muse, M. D.

(Address) 103 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Uniontown Carroll Co Md — DATE OF BURIAL: Aug 2 1921

20 UNDERTAKER: Geo W Little — ADDRESS: 2700 Edmondson Av

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55796

CERTIFICATE OF DEATH.

156 D 55796

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1461 Columbia ave ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Frank

(Residence in Baltimore: No. 1461 Columbia ave St.; 61 yrs., 9 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	widow

6-DATE OF BIRTH, Oct (Month) 21 (Day), 1859 (Year)

7-AGE, 61 yrs. 9 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Maid 070
(b) General nature of industry, business, or establishment in which employed (or employer): Family

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Conrad Staubitz

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Mary Gring

13-BIRTHPLACE OF MOTHER (State or Country), Balto County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Staubitz

(Address) 675 W Baltimore St

15- BORKE & KRAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Asphyxiation by illuminating Gas Suicide

(Duration) ..... yrs. Sudden ds.

CONTRIBUTORY (Secondary) Despondency

(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) James M. Fenton M. D. (Coroner.)

July 31 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL ~~OR REMOVAL~~, Woodlawn

DATE OF BURIAL, Aug 2, 1921

20-UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH must be stated in plain English. See that all questions are answered. Every certificate must be complete and correct in all important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

) 55797

HEALTH DEPARTMENT—CITY OF BALTIMORE

) 55797

CERTIFICATE OF DEATH.

41

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 924 Hanover ST., 23 WARD

2-FULL NAME Wallburga Schroeder

(a) RESIDENCE NO. 924 Hanover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 59 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis H. Schroeder

6 DATE OF BIRTH (month, day, and year) Feb 25 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ( ) None

(b) General nature of industry, business, or establishment in which employed (or employer) ( )

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Prussia

PARENTS

10 NAME OF FATHER Dont Known

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Prussia

12 MAIDEN NAME OF MOTHER Marian Hoch

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Prussia

14 Informant Mary Schroeder

(Address) 924 Hanover St

15 AUG 1 1921 Filed ..... 19 ..... Registrar

CAUSE OF DEATH. See instructions on reverse side. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1921, to July 29, 1921, that I last saw her alive on July 29, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of intestines.

(duration) yrs. 9 mos ... ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Maylook Willis M. D.

, 19 (Address) 810 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL Aug 1 1921

20 UNDERTAKER F. A. Krause & Son

ADDRESS 703 Hanover

Spec.—8-24-14—M. & T.—2000 Bks.

D 55798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55798

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Singer Ave. St., 27th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Florence F. Shawen

(Residence in Baltimore: No. 6 Singer Ave. or 3440 Park Hgts. Ave. St.; 2 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH. June (Month) 6 (Day), 1855 (Year)

7-AGE. 66 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nothing
(b) General nature of industry, business, or establishment in which employed (or employer)..... Not employed at anything

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Shawen

11-BIRTHPLACE OF FATHER (State or Country), Do not know

12-MAIDEN NAME OF MOTHER Elizabeth Motts

13-BIRTHPLACE OF MOTHER (State or Country). Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Ethel T. Emmanuel

(Address).. 6 Singer Ave., Balto

15-

Filed AUG 1 - 1921, 191.....

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 23rd 1921, to July 31st 1921, that I saw her alive on July 31st 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage, 6/23/21, with improvement to recurrence on 7/26/21 (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) O. H. Hoffman, M. D.

7-31-, 1921 (Address) 3402 Walbrook Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Martinsburg W. Va. DATE OF BURIAL, Aug. 3, 1921

20-UNDERTAKER Chas. E. Franck ADDRESS 42 Madison Av

CAUSE OF DEATH must be stated plainly and accurately. Indefinite terms, such as "Heart Failure," "Old Age," "Exhaustion," "Convulsions," "Paralysis," "Dropsy," "Cancer," "Tumor," "Abscess," "Childbirth," "Fever," "Pneumonia," "Consumption," "Tuberculosis," "Meningitis," "Blood Poisoning," "Septicemia," "Uremia," "Asthma," "Bronchitis," "Diarrhea," "Colitis," "Enteritis," "Hernia," "Intussusception," "Obstruction," "Ulceration," "Hemorrhage," "Jaundice," "Debility," "Senility," "Marasmus," "Malnutrition," "Infection," "Inflammation," "Congestion," "Suppression," "Suppuration," "Gangrene," "Embolism," "Thrombosis," "Shock," "Coma," "Delirium," "Spasm," "Stricture," "Rupture," "Accident," "Injury," "Fracture," "Contusion," "Laceration," "Wound," "Drowning," "Burns," "Scalds," "Asphyxia," "Poisoning," "Homicide," "Suicide," "Execution," "Unknown," "Undetermined," "Not Known," "Not Stated," "Not Specified," "Not Given," "Not Ascertained," "Not Diagnosed," "Not Known to Informant," "Not Known to Physician," "Not Known to Undertaker," "Not Known to Coroner," "Not Known to Medical Examiner," "Not Known to Health Department," "Not Known to Registrar," "Not Known to Clerk," "Not Known to Anyone," "Not Known to Me," "Not Known to Us," "Not Known to Them," "Not Known to Him," "Not Known to Her," "Not Known to It," "Not Known to Them," "Not Known to Us," "Not Known to Me," "Not Known to Anyone," "Not Known to Clerk," "Not Known to Registrar," "Not Known to Health Department," "Not Known to Medical Examiner," "Not Known to Coroner," "Not Known to Undertaker," "Not Known to Physician," "Not Known to Informant," "Not Known," "Not Stated," "Not Specified," "Not Given," "Not Ascertained," "Not Diagnosed," "Not Known to Informant," "Not Known to Physician," "Not Known to Undertaker," "Not Known to Coroner," "Not Known to Medical Examiner," "Not Known to Health Department," "Not Known to Registrar," "Not Known to Clerk," "Not Known to Anyone," "Not Known to Me," "Not Known to Us," "Not Known to Them," "Not Known to Him," "Not Known to Her," "Not Known to It," "Not Known to Them," "Not Known to Us," "Not Known to Me," "Not Known to Anyone," "Not Known to Clerk," "Not Known to Registrar," "Not Known to Health Department," "Not Known to Medical Examiner," "Not Known to Coroner," "Not Known to Undertaker," "Not Known to Physician," "Not Known to Informant," are not sufficient. Important. See instructions on back of certificate.

Misc.—6-9-19—H. P. Co.—1000 Bks.

55799

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. B 55799

54

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Blizzard.

(a) RESIDENCE. NO. unknown. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 10 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	10	17	

8 OCCUPATION OF DECEASED 073

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Driver

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Williams. Blizzard

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Heller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant [illegible]
(Address) Warden Md. Penitentiary

15 Filed AUG 1 1921 [illegible] Registrar
Social Service Dept.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1921

17 I HEREBY CERTIFY, That I attended deceased from January 19, 1921, to July 27, 1921, that I last saw h[illegible] alive on July 26, 1921, and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Edema, Exhaustion
Cardiac Failure

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. 6 mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood test

(Signed) William D. Edwards, M. D.

July 29, 1921 (Address) Md. Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery. DATE OF BURIAL Aug 1 '21

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

CAUSE OF DEATH. See instructions on back. TION is very important.

Givvines

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55800

CERTIFICATE OF DEATH.

151 D 55800

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 900 S Eutaw ST. 756 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estella Givvines

(Residence in Baltimore: No. 900 S Eutaw St St.; yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6-DATE OF BIRTH, July 6, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 26 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 900

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Givvines

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Givvines

(Address) 900 S Eutaw St

15- AUG 1-1921

Filed ....., 191... ....., Registrar.

N. B.—Every item must be answered. If unknown, state so. CAUSE OF DEATH in plain terms. All items important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Adams Bond M. D.
(Coroner)

July 1, 1921 (Address) 1000 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel Cemetery	July 2, 1921
20-UNDERTAKER	ADDRESS
H. Sanders & Sons	1710 Pleasant St

Dec.—6-9-19—H. P. Co.—1000 Bks.

55801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

136 D 55801

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 Eastern ave ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ferraro

(a) RESIDENCE. NO. 1004 Eastern av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a If married, widowed, or divorced
HUSBAND of (~~or WIFE~~) of Pasquale Ferraro

6 DATE OF BIRTH (month, day, and year) March 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Lemeo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Madeline Bachgiupa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Pasquale Ferraro (Address) 1004 Eastern ave

15 Filed , 19 ROBERT J. KRAUTH Registrar

AUG 7 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to July 30, 1921, that I last saw h~~e~~r alive on July 30, 1921, and that death occurred, on the date stated above, at 100 P m.

The CAUSE OF DEATH* was as follows:

Shock following operation for Carcinoma of Uterus

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Valvular lesion of Heart (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? High Forceps Forceps Date of July 28-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

(Address) 2 N. Oden 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents

DATE OF BURIAL Aug 1921

20 UNDERTAKER Wendell Dysel & Son

ADDRESS 312 Mun

CAUSE OF DEATH: ATTENTION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55802 ✓

D 55802 CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Municipal Tuberculosis Hospital ST. 2-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Brown

(a) RESIDENCE. NO. No address ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs mos ds How long in U. S., if of foreign birth? yrs mos ds (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal e	Colored	Single

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Sarah Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Hospital Records
(Address) M.T.H.

15 FILED AUG 1-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 21

17 I HEREBY CERTIFY, That I attended deceased from June 15 . 19 21. to July 29 . 19 21.
that I last saw him alive on July 28 . 19 21.
and that death occurred, on the date stated above, at 6.20 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(durntion) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Municipal Tbc. Hospital. M. D.
7-29-21 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19 AUG 4 1921

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55803

CERTIFICATE OF DEATH.

150 D 55803

1-PLACE OF DEATH 1742 E. Oliver, St

CITY OF BALTIMORE: (No 1742 E. Oliver ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Louise Spamer

(a) RESIDENCE. No. 1742 E. Oliver ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William O Spamer
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md
12 MAIDEN NAME OF MOTHER Elizabeth Friedloff
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila, Pa.

14 Informant Mrs Wm Elizabeth Spamer
(Address) 1742 E. Oliver St

15 AUG 1 - 1921 [illegible] & KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to July 30, 1921, that I last saw her alive on July 30, 1921, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows: Mitral Insufficiency

OVER

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual clinical tests

(Signed) C. D. Macleod, M. D.

July 30, 1921 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shelly Cemetery	Aug 1. 1921
20 UNDERTAKER Robt J Turner Sons	ADDRESS 1442 N Broadway

CAUSE OF DEATH in plain terms. Do not use abbreviations or initials. Name of contagious disease is not sufficient. Fill in all blanks. Be sure to answer every question. Write plainly. Use ink. Do not write across the face of this certificate. Do not fold. Do not roll. Do not write on back of certificate. TION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably congenital malformation of head.

55804

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 17 Jost. Hospital St.: 9 WARD)

REGISTERED No. C 186

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Almira Griffin

(Residence in Baltimore: No. 611 Calhoun and St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	colored	Single

6-DATE OF BIRTH, June (Month) 21 (Day), 1910 (Year)

7-AGE, 11 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

PARENTS.

9-BIRTHPLACE. (State or Country), Balto md

10-NAME OF FATHER. Harry Griffin

11-BIRTHPLACE OF FATHER (State or Country). Balto md.

12-MAIDEN NAME OF MOTHER Mary West

13-BIRTHPLACE OF MOTHER (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Griffin

(Address) 2222 Preston Place.

15- AUG 1 - 1921 Filed....., 191... ROBERT J. KRAUTH Serial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic bullet wound in head.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Hart Instley M. D. (Coroner)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cem. DATE OF BURIAL, 8/1/21, 19....

20-UNDERTAKER Geo. J. Ruth ADDRESS 735 Hanford Ave

CAUSE OF DEATH must be plainly written. Every item important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

091

D 55805

CERTIFICATE OF DEATH.

104

D 55805

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.:) 19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita Smith.

(a) RESIDENCE. NO. #1809 Ramsay St. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 31/1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~2 1920~~	1	8	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant (Address) Mrs. Anna Smith 809 Ramsay St.

15. Filed AUG 1 - 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-1 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-30, 1921, to 8-1, 1921, that I last saw her alive on 8-1, 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Summer diarrhea

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dudley P. Bowie, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Aug 2 19 21

20 UNDERTAKER: H B Nippert — ADDRESS: 2236 Frederick Av

CAUSE OF DEATH must be stated. See instructions on back. TION is very important.

Dec.—6-9-19—H. P. Co.—1000 Eks.

55806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55806

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH ~~University Hospital~~ 120

CITY OF BALTIMORE: No. Lawbord & Green ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmminie Zeller

(a) RESIDENCE. NO. 1801 North Register ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of William Henry Zeller

6 DATE OF BIRTH (month, day, and year) Aug 3 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	63	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Wegens

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Barbara Klein

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant David Augustus Zeller (Address) 1610 E 29th Street

15 Filed AUG 1 - 1921 BOWERY & KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1921, to July 30, 1921, that I last saw her alive on July 30, 1921, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Carcinoma arteriosclerosis Chronic diffuse nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) W. B. Jones, M. D.

19 (Address) Emergency Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL Aug 3 1921

20 UNDERTAKER H B Kuppert ADDRESS 2336 Fleet Ave

CAUSE OF DEATH. See instructions on reverse side. TION is very important.

D 55807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

REGISTERED NO. C 55807

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1429 Cookson Dr St.: Nwd WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles Goedsraw.

(Residence in Baltimore: No. 1429 Cookson Dr St.: 4yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (If Write the word)
Male	White	Single

6 DATE OF BIRTH November 18, 1920
(Month) (Day) (Year)

7 AGE ..... yrs. 8 mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James R Goedsraw

11 BIRTHPLACE OF FATHER (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary E Peterson

13 BIRTHPLACE OF MOTHER (State or country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E. Goedsraw

(Address) 1429 Cookson

15 Filed AUG 1 - 1921 ROBERT A KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 31, 1921
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1921, to July 31, 1921, that I saw h[illegible] alive on July 30, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Meningitis Tuberculosis

(Duration) ..... yrs. ..... mos. 10 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos Fa Stevens M. D.

July 31, 1921 (Address) 2875 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bloomfield	8/1, 1921
20 UNDERTAKER	ADDRESS
J. Robertson	1111 Eutaw

N. B.—Every item of information should be given, so that it may be properly recorded. In particular state CAUSE OF DEATH in plain terms, so that it may be properly classified. The date of burial is very important. See instructions on back of certificate.

Dec.—6-9-19—H. P. Co.—1000 Bks.

D 55808 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55808

CERTIFICATE OF DEATH. REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3013 O'Donnell ST.: 1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Betz.

(a) RESIDENCE. NO. 3013 O'Donnell ST., 1 WARD.
(Usual place of abode)
Length of residence in city or town where death occurred five yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 13-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer American Wholesale Corp. Baltimore

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John B. Betz

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia A. Lidard

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant (Address) Julia A. Betz. 3013 O'Donnell St.

15 Filed ..., 19... Registrar

AUG 1 — 1921 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921 to July 31, 1921, that I last saw h-er alive on July 31, 1921, and that death occurred, on the date stated above, at 2.15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Endocarditis (duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) W B Tedlow M. D.

8/1, 1921 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery

DATE OF BURIAL Aug 2 1921

20 UNDERTAKER Zickler + Zickler

ADDRESS 1739 E. Eager St.

CAUSE OF DEATH. See instructions on reverse side. TION is very important.

ec.—6-9-19—H. P. Co.—1000 Bks.

D 55809 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 55809

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Bouldin ST.: No (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Corliss

(a) RESIDENCE. NO. 1001 S. Bouldin ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 12. 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. ...min.
	7	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John J. Corliss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Lena Witzke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John Corliss 1001 S. Bouldin St.

15 Filed . 19 ROBERT J. KRAUTH Registrar

AUG 1 - 1921 Burial Permit Clerk

CAUSE OF DEATH. See instructions on reverse side. IMPORTANT. See instructions on reverse side. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1921, to July 31, 1921, that I last saw him alive on July 31, 1921, and that death occurred, on the date stated above, at 8 P. m. The CAUSE OF DEATH was as follows:*

Acute Catarrhal Enteritis

7 (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. K. Meyer Jr. M. D.

8/1, 1921 (Address) 1138 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patrick's Cemetery	Aug 3 1921
20 UNDERTAKER	ADDRESS
Jenkins & Jenkins	1739 E. Eager St.

ec.—6-9-19—H. P. Co.—1000 Blks.

D 55810

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 55810

CERTIFICATE OF DEATH.

91 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3123 Dillon ST.: 1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. C. Schirmer

(a) RESIDENCE. NO. 3123 Dillon ST.. 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	7	

8 OCCUPATION OF DECEASED — 000

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. C. Schirmer

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Harriet Evans

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Md.

14 Informant Wm. C. Schirmer
(Address) 3123 Dillon St.

15 Filed AUG 1 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH. See instructions on reverse side. This information is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1921

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1921, to July 31, 1921, that I last saw h— alive on July 31, 1921, at 4 a. m. and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. mon. 6 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? 2nd Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Observation

8/1, 1921 (Signed) H B Fillow, M. D.
(Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL Aug 2 1921

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager

D 55811 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55811

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Catt & Market Space on dep St. 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME a. allen or Russell

(Residence in Baltimore: No. St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	?

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE. about 49 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Odd ...
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) .....

15- AUG 1 1921 Robert P. Harrison,
....., 191.....
Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac asthma
Diabetes Contributory (?)
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
July 27, 1921 (Address) 1637 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, ..., 19....

20-UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND

CAUSE OF DEATH in plain terms, ... important. See instructions on back of certificate.

Spec.—1-19-21—MAT—1500 Blks.

D 55812

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55812

CERTIFICATE OF DEATH

REGISTERED NO. 150

1-PLACE OF DEATH 3415 E Balto St

CITY OF BALTIMORE: (No. 3415 E Baltimore (WARD) 170

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Goetz

(a) RESIDENCE NO. 3415 E. Balto. ST., WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred X yrs. X mos. 9 ds. How long in U. S., if of foreign birth? X yrs. X mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): July 22-1914

7 AGE: Years 2 Months X Days X If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John Goetz

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Freda Hahne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: John Goetz (Address) 3415 E Baltimore

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to July 31, 1921, that I last saw h[illegible] alive on July 30, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Obstruction Congenital Heart

(duration) X yrs. X mos. 10 ds.

CONTRIBUTORY (Secondary) Congenital Malform Heart (duration) X yrs. X mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? None Date of

Was there an autopsy? No

What confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

(Address) 248 [illegible]

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross

DATE OF BURIAL: 8/1 1921

20 UNDERTAKER: J J Moran

ADDRESS 3 [illegible] Balto

CAUSE OF DEATH to be plainly written. See instructions on back of Certificate. TION is very important.

G 1—1921

Dec.—6-1-19—H. P. Co.—1000 Bks.

D 55813 HEALTH DEPARTMENT—CITY OF BALTIMORE 80 D 55813

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marlborough Aprts., ST.: 14 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jonas Baird Weil,

(a) RESIDENCE. NO. Eutaw Place & Wilson St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White,	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Weil

6 DATE OF BIRTH (month, day, and year) Aug. 6th. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired, OH

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Bus.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jonathan Weil,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER Babette Stern,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany,

14 Informant (Address) Mrs. Hannah Weil Marlborough Aprts

15 Filed ..... 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk.

G 1 - 1921

CAUSE OF DEATH. See instructions on back. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30 . 1921 . to July 31 . 1921 . that I last saw him alive on July 30 . 1921 . and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arter. sclerosis?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of /

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) I. Frederick Lenz, M. D.

7/31, 1921 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship,	Aug. 2nd. 1921

20 UNDERTAKER David Sandheim ADDRESS 1115 W. Mt. Royal

D 55814 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55814

CERTIFICATE OF DEATH.

REGISTERED NO. C 479

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 642 W Fayette ST. 4 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nora M. Bierbaum
(Residence in Baltimore: No. 642 W Fayette St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dont Know (Month) (Day), 1 (Year)

7-AGE, 44 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER, John Smith
11-BIRTHPLACE OF FATHER (State or Country). Md
12-MAIDEN NAME OF MOTHER Mary Gladfelt
13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs S Bierbaum
(Address) 642 W. Fayette St.

15-
Filed, 191. Registrar.
Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(inquest, autopsy or inquiry.)~~ find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Valvular disease of Heart
(Duration) Dont Know yrs. mos. ds.
CONTRIBUTORY (Secondary) Dont Know
(Duration) yrs. mos. ds.
(Signed) M K Gwinch M. D.
(Coroner)
8-1, 1921 (Address) 117 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park
DATE OF BURIAL, Aug 3, 1921
20-UNDERTAKER W M Cook
ADDRESS 502 Northern

CAUSE OF DEATH in plain terms. Important. See instructions on back of certificate.

8-1-1921

Dec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55815

D 55815

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 316 S ann ST.: 7 WARD)

2-FULL NAME Edward Buraczynski

(a) RESIDENCE. NO. 316 S ann ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Andrew Buraczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Cecila Rybarczyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Andrew Buraczynski 316 S ann St

15 Filed Aug 1 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1921, to 7-31, 1921.

That I last saw he alive on 7-31, 1921

and that death occurred, on the date stated above, at 9.30 8 m.

The CAUSE OF DEATH* was as follows:

Summer diarrhoea

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. Seymour, M. D.

8-1-21 (Address) 2528 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	aug 2 1921

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank

CAUSE OF DEATH IS VERY IMPORTANT. See instructions on

spec.—6-9-19—H. P. Co.—1000 Bks.

D 55816

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55816

50

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Franklin square Hospital ST. (or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Hopps

(a) RESIDENCE. NO. 1832 N Caroline St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~~Married~~ Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 27=1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Monroe & Monroe Co

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Retail

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jefferson Hopps

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) M J Hopps 1832 Caroline St

15 Filed Aug 1 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-21 19

17 I HEREBY CERTIFY, That I attended deceased from 10 PM 7-30-21 19 to 5:20 am 7-31-21 19, that I last saw h live on at 5.19 am 7-31-21 19, and that death occurred, on the date stated above, at 5:20 am m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Howard M. Bubis, M. D

19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 3 1921
20 UNDERTAKER	ADDRESS
Henry Lutz	1007 N. Bond St

TION is very important. See instructions on

Dec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55817

D 55817

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1000 Monroe Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Patrick Hebron

(a) RESIDENCE. NO. 1000 Monroe Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of — (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs Ethel A. Hood

9 BIRTHPLACE (city or town) (State or country) Sugarland Md.

PARENTS

10 NAME OF FATHER Wm Hebron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sugarland Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Wife Mrs Wm P. Hebron

(Address)

15 Filed . 19 Robert P. Harrison, Registrar

AUG 1-1921 Burial Permit Clerk.

CAUSE OF DEATH. See instructions on reverse side. IMPORTANT. CERTIFICATION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. , 1921 , to July 31 , 1921 ,

that I last saw h alive on July 30 , 1921 ,

and that death occurred, on the date stated above, at 6 45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Laboratory Test

(Signed) H. B. Wheaton , M. D.

, 19 (Address) 1431 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sugarland Montgomery Co. Md

DATE OF BURIAL Aug 3 1921

20 UNDERTAKER John H. Toadvine

ADDRESS 142 W. Hill St

spec.—6-9-19—H. P. Co.—1000 Bks.

D 55818 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55818

CERTIFICATE OF DEATH. 60

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard F. Rochfort

(a) RESIDENCE. NO. 2310 Ashland Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Rochfort

6 DATE OF BIRTH (month, day, and year) Nov 18- 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer 009

(b) General nature of industry, business, or establishment in which employed (or employer) Clerical work.

(c) Name of employer B & O R.R

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas C. Rochfort

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~Ireland~~ England

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md

15 Filed . 19 Registrar

Robert F. Harrison, 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18th, 1921, to July 29th, 1921, that I last saw h in alive on July 29th, 1921, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cerebritis - (Post Heat exhaustion with Cerebral Congestion) 0731

abt (duration) 0 yrs. 0 mos. 18 ds.

CONTRIBUTORY (Secondary) Acute Mania -

(duration) 0 yrs. 0 mos. 18 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

July 20, 1921 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery	Aug 2 1921
20 UNDERTAKER Chas. J. Bonnus & Son	ADDRESS 118 N. Mt Royal.

CAUSE OF DEATH. See INSTRUCTIONS on back. This is very important.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not traumatic. Wife ill at Lowell. Rec'd over to visit her during hot weather three & four times a day. Worry & heat

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55819

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55819

CERTIFICATE OF DEATH.

REGISTERED NO. 4 X 146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Chas. F. Carlin

(a) RESIDENCE. No. Adamstown, Frederick, Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of — Mrs Eva Carlin

6 DATE OF BIRTH (month, day, and year) July 13, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer Fred Dept.

(b) General nature of Industry, business, or establishment in which employed (or employer) — 045

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John D. Carlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Hummel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John F. Carlin Route No 6

(Address) Frederick Co. Md.

15 Filed Aug 2 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1921, to Aug 1, 1921.

that I last saw h. alive on Aug 1, 1921.

and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(duration) yrs. mos. 1 7 ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Mercy Hospital

Did an operation precede death? No Date of

Was there an autopsy? (Yes, No, Unknown)

What test confirmed diagnosis? Signs Symptoms

(Signed) John C. Carlin, M. D.

, 19 (Address) Emergency Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Aug 2 1921

20 UNDERTAKER Chas. F. Evans, Jr. ADDRESS 118 N. Mc Cay

CAUSE OF DEATH. See instructions on back of CERTIFICATE. TION is very important.

J 1 — 1921

Spec.—8-24-14—M. & T.—2000 Bks.

D 55820

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55820

CERTIFICATE OF DEATH.

109

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1211 annapolis ave ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME Walter L. Breen

(Residence in Baltimore: No. 1211 annapolis ave St. Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 8 (Month) 30 (Day), 1897 (Year)

7-AGE, 24 yrs. 11 mos. 29 ds. If LESS than 1 day, .. hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Elevator Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): 030

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Patrick Breen

11-BIRTHPLACE OF FATHER (State or Country), Ired

12-MAIDEN NAME OF MOTHER Sarah E. Shannon

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mamie Breen

(Address) 1211 Annapolis Ave

15-

Filed ..., 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

AUG 1 1921

important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 31 1921, to July 31 1921, that I saw h in alive on 7 31 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: obstruction of bowel

(Duration) ... yrs. ... mos. 1 ... ds.

CONTRIBUTORY (Secondary) Hemorrhage of Stomach

(Duration) ... yrs. 2 mos. ... ds.

(Signed) Thos. B. Stace M. D.

..., 191... (Address) Faulkner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, July 23, 1921

20-UNDERTAKER Harry H. Witzke

ADDRESS 1531 Lombard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 55821

D 55821

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 So. Monroe St. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Slingerland

(a) RESIDENCE. NO. 116 So. Monroe St. ST., WARD.

(Usual Place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriett Slingerland

6 DATE OF BIRTH (month, day, and year) Jan. 4" 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired-Machinist 031

(b) General nature of Industry, business, or establishment in which employed (or employer) Crown Cork & Seal

(c) Name of employer Co.

9 BIRTHPLACE (city or town) Laurel

(State or country) Md.

PARENTS

10 NAME OF FATHER Peter Slingerland

11 BIRTHPLACE OF FATHER (city or town)

(State or country) U. S.

12 MAIDEN NAME OF MOTHER Martha Mc Hugh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) U. S.

14 Informant Harriett Slingerland

(Address) 116 S. Fulton Ave.

15 Filed AUG 2 - 1921 ROBERT I KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30th, 1921, that I last saw him alive on July 23rd, 1921, and that death occurred, on the date stated above, at 4.35 P m.

The CAUSE OF DEATH* was as follows:

Epithelioma of face and throat

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. D. Gilbert, M. D.

8/1, 1921 (Address) 211 N Lamora

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 2" 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 N. Gilto St.

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms. so that it may be understood. See instructions on back of CAUSE OF DEATH is very important. See instructions on back of TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55822

55822

CERTIFICATE OF DEATH.

81

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Methodist Age Home (St.) 20 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily J. Amos

(Residence in Baltimore: No. C Franklin & Fulton Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 91 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER. Alexander Amos

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Bennett

(Address) 400 Fulton ave

15-

Filed AUG 2 - 1921 19.... ROBERT J. KRAMER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

..... (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Jesse M Fenton M. D. (Coroner)

Aug 2, 1921. (Address) 70 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem.	8/2/21 19....
20-UNDERTAKER	ADDRESS
Geo J Smith	1300 W Pratt

CAUSE OF DEATH to be filled in plainly and completely. Every question important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55823 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55823

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 Dellwood Ave St. 13 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nancy B. Hahn

(Residence in Baltimore: No. 1218 Dellwood Ave St.; 30 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Apr 25, 1865 (Month) (Day) (Year)

7-AGE, 56 yrs. 3 mos. 5 da. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, John B. Harris

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co Md

12-MAIDEN NAME OF MOTHER, Catherine Bobbitz

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otto Hahn

(Address) 1218 Dellwood Ave

15- AUG 2 - 1921 Filed ..... 191... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1921, to July 1921, that I saw her alive on July 30 1921, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

A Acute Pulmonary Edema

(Duration) ....yrs....mos....da.

CONTRIBUTORY (Secondary) Chronic Nephritis, Hypertension

(Duration) 2 yrs. ....mos. ....da.

(Signed) Frank H. Marshall M. D.

....., 191... (Address) 1111 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Druid Ridge	Aug 7, 1921
20-UNDERTAKER	ADDRESS
H. S. Marshall	353 Park Ave

important. See instructions on back of

Sec.—6-9-19—H. P. Co.—1000 Bks.

D 55824

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55824

CERTIFICATE OF DEATH.

24 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 201 East Cross ST.: WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Hubbard

(a) RESIDENCE. No. 201 East Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

3a If married, widowed, or divorced (or) WIFE of Thomas H Hubbard

6 DATE OF BIRTH (month, day, and year) Jan 9 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Off

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER Alexander Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mary A Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

14 Informant Mrs Charles E Tracy

(Address) 238 E Montgomery St

15 Filed AUG 2 - 1921 LOUIS I KRAUTH Registrar

Burial Permit Given

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 13 - 1919 to July 31st 1921, that I last saw h[illegible] alive on July 30th 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) E E Burton, M. D.

8/1/ 1921 (Address) 301 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	Aug 2 1921
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55825

CERTIFICATE OF DEATH.

8 50

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1513 N. Bond ST.: WARD)

2-FULL NAME Mary A Murphy

(a) RESIDENCE. No. 1513 N Bond ST., [redacted]RD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick J. Murphy

6 DATE OF BIRTH (month, day, and year): Oct 7-1857

7 AGE: Years 63 Months 9 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Mathew J. Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Kavanaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mary E. Henry 1513 N. Bond St.

15 Filed AUG 2-1921 ROBERT A KRAUTH Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 26 . 1921 . to July 31 . 1921 . that I last saw h[illegible] alive on July 30 . 1921 . and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis + Diabetes

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James McFeaters, M. D.

19 (Address) 705 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Aug 3, 1921

20 UNDERTAKER: H. C. Wiedefeld ADDRESS 914 Greenmt Ave

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55826

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55826

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard K. Pasko

(a) RESIDENCE. NO. 124 S. Wolfe St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 25-1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacek Pasco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Blandowicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Jacek Pasko. Father

(Address) 124 S. Wolfe St.

15 AUG 2-1921 ROBERT J. KRUTKE Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from aug 1. 1921. to aug 1. 1921.

that I last saw him alive on aug 1. 1921.

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal 2 ds.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological M. D.

(Signed) B. Macpherson

8/2/21 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Aug 2" 1921.
20 UNDERTAKER M. J. Sadowski.	ADDRESS 705 S. Ann

mation should be given in plain terms, so that it may be understood by the public. CAUSE OF DEATH in plain terms, so that it may be understood by the public. CAUSE OF DEATH is very important. See instructions on back of certificates.

Dec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55827

REGISTERED No. 31 1921 893 884

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 Somerset ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Banks

(a) RESIDENCE. NO. 521 Somerset ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alfred Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robt. Banks (Address) 527 Somerset St

15 Filed AUG 2 - 1921 . 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-1921

17 I HEREBY CERTIFY, That I attended deceased from 7-30-, 1921, to 7-31-, 1921, that I last saw him alive on 7-31-, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. W. Longwell, M. D.

7-31, 1921 (Address) 611 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel DATE OF BURIAL Aug 3 1921

20 UNDERTAKER Harmon & Wright ADDRESS 307 Mary

CAUSE OF DEATH. See INSTRUCTION is very important.

D 55828

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 91

D 55828

CERTIFICATE OF DEATH.

REGISTERED NO. C 15 47

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1313 N. Stockton St. WARD)

2-FULL NAME Mary Campbell

(Residence in Baltimore: No. 1313 N. Stockton St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
female	colored	single

6-DATE OF BIRTH, Sept. 20, 1906
(Month) (Day) (Year)

7-AGE, 14 yrs. 10 mos. 11 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... student
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Pennsylvania

PARENTS.

10-NAME OF FATHER, Joshua Campbell

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Maggie Hawkins

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maggie Campbell

(Address) 1313 N. Stockton St.

15- AUG 2 1921 ROBERT I. KRAETER Registrar.
Filed ....., 191.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the date stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute rheumatic fever

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

Aug. 1, 1921. (Address) 502 E. Lemmon St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn

DATE OF BURIAL, Aug. 3, 1921

20-UNDERTAKER Barnum & English

ADDRESS 536 W. Lanvale

CAUSE OF DEATH to be important. See instructions on back of certificate.

Dec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55829 — REGISTERED NO. D 55829

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1505 Jefferson St.: 6 Ward)

2-FULL NAME Louisa C. Hagerman

(a) RESIDENCE. No. 1510 Jefferson St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60 apparently	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife (General housework)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Philip Hagerman

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Harriet Wells

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)

14 Informant Mrs. John F. Hagerman (Husband)
(Address)

15 Filed AUG 2 - 1921 [illegible] Registrar

Burial Permit Given

CAUSE OF DEATH. Information is very important. See instructions on reverse side.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31 1921

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1921, to July 31, 1921, that I last saw h[illegible] alive on July 31, 1921, and that death occurred, on the date stated above, at 7.05 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) .... yrs. .... mos. 1 ds.

CONTRIBUTORY (Secondary) Hemiplegia Cerebral Hemorrhage (duration) .... yrs. 2 mos. .... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Findings —

What test confirmed diagnosis? Symptoms & Signs

(Signed) R. F. Hagerman, M. D.

, 19 (Address) 1716 Jefferson

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL 8/3/21 19

20 UNDERTAKER Thos White 113 Mulberry ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

D 55830 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 64 D 55830

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 Gough ST.; 3 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johanna Magnuson

(Residence in Baltimore: No. 1512 Gough St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... Jan (Month) 2 (Day), 1847 (Year).

7-AGE, 74 yrs. 7 mos. ..... ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Kaspar

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl A. Magnuson

(Address) 1512 Gough St.

15- Filed AUG 2 1921 191.....

ROBERT F. TRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 31 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from June 2 1921 to July 31 1921, that I saw her alive on July 30 1921, and that death occurred, on the date stated above, at 10-25 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

..... (Duration) 5 yrs, 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Arterio sclerosis

..... (Duration) over 2 yrs. mos. ds.

(Signed) Henry C. ..... M. D.

Aug. 1..., 1921. (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery | DATE OF BURIAL, 8/3/..., 1921.

20-UNDERTAKER J. A. Inman | ADDRESS 2 Bartlett

important. See instructions on back.

pec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 55831

CERTIFICATE OF DEATH.

55831

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Robinson

(a) RESIDENCE. NO. ✓ ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Black	-

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 28, 1921

7 AGE	Years	Months	Days	If LESS than 1 day ✓ hrs. or ✓ min.
	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work -

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer

9 BIRTHPLACE (city or town) Johns Hopkins Hospital
(State or country)

PARENTS

10 NAME OF FATHER Alexander Robinson

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Edwina Cole

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Johns Hopkins Hospital
(Address) 20 Gamble.

15 AUG 2 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to July 29, 1921, that I last saw h.im alive on July 29, 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth (8 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) -
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy W. Cromwell, M. D.

7/30 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

ADDRESS

20 UNDERTAKER

AUG 1 1921

Commissioner Health.

TION is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D 55832

CERTIFICATE OF DEATH.

D 55832

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View St.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas V. Sutton

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Thomas Sutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Ann Emmett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Hospital Records, New City Hospital. UNIV

15 Filed AUG 2 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1921

17

I HEREBY CERTIFY, That I attended deceased from July 19, 1921, to July 30, 1921, that I last saw him alive on July 29, 1921, and that death occurred, on the date stated above, at 2:15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

7/30/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

AUG 2 - 1921

1761

TION is very important. See instructions on

) 55833

143 D 55833

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 4000 Springdale ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence R Dashields

(a) RESIDENCE. NO. 4000 Springdale ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of John H Dashields

6 DATE OF BIRTH (month, day, and year) Sept 14th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John McMullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Carson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Florence E Hinkel 4000 Springdale ave

15 Filed AUG 2 - 1921 ROBERT I KRAUTER Registrar Social Security Clerk

CAUSE OF DEATH. See instructions on back. IMPORTANT. This information is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 1 1921

17 I HEREBY CERTIFY, That I attended deceased from jan 1, 1921, to aug 1, 1921, that I last saw her alive on July 25, 1921, and that death occurred, on the date stated above, at 8.05 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast.

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. G. Queen, M. D.

, 19 (Address) 3501 Garrison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Aug 4th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55834

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55834

CERTIFICATE OF DEATH.

REGISTERED NO. 99

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. St. Agnes Hospital ST.: 2 5 WARD

2-FULL NAME Peter M. Hansen

(a) RESIDENCE. NO. Larvik, Norway ST., WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Larvik, Norway

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Do not know 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
35				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do Not Know

14 Informant Mrs Peter Hansen
(Address) Larvik Norway

15 Filed AUG 2 — 1921 . 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-30 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-20 , 1921 , to 7-30 , 1921.

that I last saw h[illegible] alive on 7-30 , 1921.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Parotid abscess.
(Mixed tumor of parotid).

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Septicaemia (streptococcus)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? Yes. Date of 7-28-21.

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Dudley P. Bonfe M. D.

. 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn Cemetery

DATE OF BURIAL Aug 3 1921

20 UNDERTAKER Robt J Turner

ADDRESS 1442 W Mo

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back. INFORMATION is very important.

per. 6-9-19. H. P. Co.—1000 Bks.

D 55835

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55835

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Chesney

(a) RESIDENCE. No. 1508 Register st. ST.. ..... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician's helper

(b) General nature of industry, business, or establishment in which employed (or employer) 079

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Alfred Chesney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Heath

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Hospital Records U. T. H.

15 Filed Robert P. Harrison, Registrar Burial Permit Clerk

AUG 2 1921

CAUSE OF DEATH IS very important. See Instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 1921.

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1921, to August 2, 1921, that I last saw him alive on August 1, 1921, and that death occurred, on the date stated above, at 12.30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Alfred Chesney M.D.

8-2-21. 1921 (Address) Municipal Tuberculosis Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Aug 3 1921

Mrs Samuel Lindley

20 UNDERTAKER Robt Thomson & Son ADDRESS 21 Bond

D 55836 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55836

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1424 Battery Ave. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah R. Hudson.

(Residence in Baltimore: No.) 1424 Battery Ave. St.: 60 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female.	White.	Widow.

6-DATE OF BIRTH. February 19th. 1857., / (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
64 yrs. 5 mos. 13 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Dorchester Co. Md.

PARENTS.

10-NAME OF FATHER. Thomas H. Abbott.

11-BIRTHPLACE OF FATHER (State or Country). Dorchester Co. Md.

12-MAIDEN NAME OF MOTHER. Wilhelmina Carr.

13-BIRTHPLACE OF MOTHER (State or Country). Dorchester Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William T. Hudson. (son)

(Address) 1424 Battery Ave.

15- Filed ....., 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

2-1921

CAUSE OF DEATH. This information is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1st. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valuular disease of the Heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Thos. H. Emmart M.D. (Coroner.)

Aug. 2...., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem	8/3..., 1921
20-UNDERTAKER	ADDRESS
J. Fred McCally	130 E. Fort

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55837

D 55837

CERTIFICATE OF DEATH.

16 184

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Mosher ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Chance

(Residence in Baltimore: No. 1210 Harlem ave St.: 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

~~3-SEX.~~ Fem

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. July 20, 1900
(Month) (Day) (Year)

7-AGE. 21 yrs. mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer). 637

9-BIRTHPLACE, (State or Country). Howard Co

PARENTS.

10-NAME OF FATHER. Louis E Stanton

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Lizzie Peterman

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Stanton

(Address) Woodbine Howard Co

15- Filed AUG 2 1921, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19 1924, to July 31 1924, that I saw her alive on July 31 1924, and that death occurred, on the date stated above, at 10.45 P.M.

The CAUSE OF DEATH was as follows:

Puerperal Septicemia
Criminal Abortion (Abortion)
Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia
(Duration) yrs. mos. 1 ds.

(Signed) W. T. Coleman M. D.

Aug 1, 1924 (Address) 903 E. McCulloh St

•State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Dansey Howard Co

DATE OF BURIAL, Aug 3, 1921

20-UNDERTAKER Sam'l H. Chase Son

ADDRESS 1400 Mosher

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55838 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 55838

CERTIFICATE OF DEATH. 108

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 22 WARD)

2-FULL NAME Vernon P. Huddle

(a) RESIDENCE. NO. 1437 William ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Inspector 173

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer R. R. Co

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER A. B. Huddle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Propes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant W. S. Huddle
(Address) 5 Dolphin Ave

15 Filed Robert P. Harrison, Registrar
G2-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29th, 1921, to Aug 1st, 1921.

That I last saw h Alive on Aug 1st, 1921.

and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Ceculs Appendicitis (Acute)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Thrombosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 29, 1921

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Leo A Wrang, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Summerdale Cem

DATE OF BURIAL Aug. 1921

20 UNDERTAKER John F. Schnepfau

ADDRESS 1000 Eden St.

BEFORE writing, read carefully the directions on back of certificates. CAUSE OF DEATH in plain terms. so that a non-medical person can understand it. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Hemons)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55839

X 108 D 55839

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: NO. Lombard & Greene Sts. ST.. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Hemore

(a) RESIDENCE. NO. Havre de Grace Md ST.. WARD. Havre de Grace Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About June - 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jarrett Hemore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Record
(Address)

15 Filed AUG 2-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1. 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to Aug 1, 1921, that I last saw him alive on Aug 1, 1921, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:—

Acute appendicitis

General Peritonitis

(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 d.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 29, 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lynn F. Howe, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Havre de Grace Md

DATE OF BURIAL 8-3 19 21

20 UNDERTAKER E & B Hale

ADDRESS 115 E Fayette

CAUSE OF DEATH to be plainly written in ink. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

Harry Moore over

145454

D 55840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.. 7 WARD)

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Moore

(a) RESIDENCE NO. Chesapeake City Md ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. 2 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 3-1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Stephen Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Blanche Lemon (dec'd)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital Record

(Address) Robert P. Harrison

15 Registrar

AUG 2-1921 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from May 27. 1921. to Aug 1st 1921.

that I last saw he alive on Aug. 1st 1921.

and that death occurred, on the date stated above, at 6.50 a.m.

The CAUSE OF DEATH* was as follows:

Xeroderma Pigmentosum

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 15, 1921

Was there an autopsy? Yes.

What test confirmed diagnosis? None

(Signed) W Harrison, M. D.

8-1, 19 21 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cokesbury Maryland

DATE OF BURIAL Aug 2 1921

20 UNDERTAKER Cook

ADDRESS 502 E Nalls

CAUSE OF DEATH in plain terms. See instructions on back of certificate. CAUSE OF DEATH is very important.

D 55841

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55841

CERTIFICATE OF DEATH.

REGISTERED No. C 169

1-PLACE OF DEATH, CITY OF BALTIMORE (No.) City Harbor, Foot of Boudin St. (Ward) 5

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Nichols

(Residence in Baltimore: No. 1423 S. Ann St.: yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	Col.	Married

6-DATE OF BIRTH, Feb 14 (Month) (Day) 1881 (Year)

7-AGE,	If LESS than 1 day,
39 yrs. 5 mos. 16 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer) /

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, D. Nichols

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Julia Stewart

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Nichols

(Address) 614 Tulip

15-

Filed ....., 191.... Registrar. Robert P. Harrison,

2-1921 Burial Permit Clerk.

CAUSE OF DEATH. See instructions on back of certificate. important.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning Accidental

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ... yrs. ... mos. ... da.

(Signed) C. C. Stadler M. D. (Coroner.)

..... 19t... (Address) 143 N. Ann

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....da. In the State ....yrs....mos....da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cemetery DATE OF BURIAL, Aug 3 1921

20-UNDERTAKER L. T. Fissellburgh ADDRESS 2670 St Paul

D 55842

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55842

CERTIFICATE OF DEATH.

REGISTERED No. C 91

PLACE OF DEATH

CITY OF BALTIMORE (No. 747 Dinwiddie St. ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Etta R. Courtney

(Residence in Baltimore: No. 747 Dinwiddie St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, March (Month) 25 (Day), 1879 (Year)

7-AGE, 2 yrs. 4 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, J. P. Courtney

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Blanch Bowley

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Courtney

(Address) 747 Dinwiddie St

15-

Filed AUG 2 - 1921 Robert P. Harris Registrar.

Burial Permit Clerk.

CAUSE OF DEATH in plain words. Omissions important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... ~~Coroner, an~~ ..... find that said deceased came to ~~his~~ her death ~~by autopsy or~~ inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Fowler M. D. (Coroner.)

8-2-, 1921. (Address) 417 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Int Auburn Cem

DATE OF BURIAL, Aug 3 1921.

20-UNDERTAKER Jas. M. Skinner

ADDRESS 1625 E. Biddle St

Spec.—1-10-21—M&T—1500 Bks.

D 55843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 55843

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3901 Forrest Park Ave 15 WARD)

2-FULL NAME George Henry Ullenberg

(a) RESIDENCE NO. 3901 Forrest Park Ave., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret L Ullenberg

6 DATE OF BIRTH (month, day, and year) Mar 22 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	59	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Mfgr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore md

(State or country)

PARENTS

10 NAME OF FATHER Herman Ullenberg

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Bruchhaus

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Margaret R Ullenberg

(Address) 3901 Forrest Park Ave

15 Filed Robert P. Harrison Registrar

2-1921 Burial Permit Clerk.

CAUSE OF DEATH. See instructions on back. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-29, 1921, to 8-1, 1921,

that I last saw h[illegible] alive on 7-31, 1921,

and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) Myocarditis - Pneumonia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur R Spencer M. D.

8/1, 1924 (Address) 2806 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Aug 3 1921

20 UNDERTAKER Wm Tuckwell & Sons ADDRESS Norfolk Va

Spec.–1-10-21–M&T–1500 Bks.

D 55844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55844

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3545 Newland Ave. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin L. Bronner

(a) RESIDENCE NO. 3545 Newland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Bronner

6 DATE OF BIRTH (month, day, and year) Oct 16 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	64	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer Self

9 BIRTHPLACE (city or town) Uperfield N.J.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Bronner

11 BIRTHPLACE OF FATHER (city or town) France
(State or country)

12 MAIDEN NAME OF MOTHER Abbey Cory

13 BIRTHPLACE OF MOTHER (city or town) N.J.
(State or country)

14 Informant Mary R. Bronner
(Address) 3545 Newland Ave

15 Filed Aug 2, 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1921

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1921, to Aug 1st, 1921, that I last saw him alive on Aug 1st, 1921, and that death occurred, on the date stated above, at 9:45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical study

(Signed) Wm. Engelhart M. D.

Aug 2, 1921 (Address) 1005 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Va

DATE OF BURIAL Aug 3 1921

20 UNDERTAKER Wm. J. Fickus & Sons

ADDRESS North E Pa

CAUSE OF DEATH MUST BE FILLED IN. ATTENTION is very important. See instructions on back.

D 55845

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55845

CERTIFICATE OF DEATH.

REGISTERED No. C 1079

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 718 n. Eden St.: 10 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maryland Turner
(Residence in Baltimore: No. 718 n Eden) St.: yrs., 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male
4-COLOR OR RACE, Col
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Divorced

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 54 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Laborer

9-BIRTHPLACE, (State or Country). Born in Balt 30 years Maryland

PARENTS.
10-NAME OF FATHER, Monthen Turner
11-BIRTHPLACE OF FATHER (State or Country), Md
12-MAIDEN NAME OF MOTHER Not Known
13-BIRTHPLACE OF MOTHER (State or Country), Not-Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Catherine Thompson
(Address) Anarandel County

15- Filed AUG 3 - 1921 [illegible] & KRAUTER Burial Permit Registered

CAUSE OF DEATH to be plainly written. All items important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) 1 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Chronic Heart Disease
..... (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... (Coroner) M. D.
....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Furnish Branch
DATE OF BURIAL, Aug 3 1921
20-UNDERTAKER Mrs R A Elliott
ADDRESS 1725 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55846 | 40D 55846

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 117 N Pearl ST.: H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christiana Mueller

(a) RESIDENCE. NO. 117 N Pearl ST.. WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of / or WIFE of) the Henry Miller

6 DATE OF BIRTH (month, day, and year) May 27, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John H. Berneburg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Miller (Address) 117 N. Pearl St.

15 Filed AUG 3 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12 1921 to Aug 1st 1921, that I last saw her alive on July 31 1921, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach X

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) X (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) V. Clan Williams M. D.

, 19 (Address) 901 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL	CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery		Aug 4 '21

20 UNDERTAKER Harry H. Witzke ADDRESS 1531 W. Lombard

CAUSE OF DEATH must be filled in. See instructions on back of Certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55847

D 55847

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul J Holland

(a) RESIDENCE. NO. 1708 Lansing Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10 - 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairmount Md

PARENTS

10 NAME OF FATHER Alger J Holland

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mamie Holland

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mamie Holland
(Address) 1708 Lansing Ave

15 Filed AUG 3 - 1921, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1921, to Aug. 1, 1921, that I last saw h.im alive on Aug. 1, 1921, and that death occurred, on the date stated above, at 4 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 3 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Septic arthritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Culture from joint.

(Signed) Frank Manard, M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmount Cem Md

DATE OF BURIAL Aug 4 1921

20 UNDERTAKER John Herring & Co

ADDRESS 1008 Orleans

TION is very important. See instructions on

Spec.—1-10 21—M&T—1500 Bks.

128 Lloyd (Bulmash) ✓

D 55848

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55848

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 Lloyd ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Bulmash (Apt 1st) Lloyd St.

(a) RESIDENCE NO. 128 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

(Length of residence in city or town where death occurred 9 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bella Bulmash

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Krupp

(Address) 1411 E Baltimore St.

15 AUG 3 - 1921 Filed ....., 19..... Burial Permit Clerk Registrar

CAUSE OF DEATH IS VERY IMPORTANT. See instructions on back of Certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1921, to Aug 3, 1921, that I last saw h[illegible] alive on Aug 3, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

1 Carcinoma of Stomach & Oesophagus

(duration) yrs. 8-10 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Nathan Helfgot, M. D.

, 19 (Address) 117 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Memorial

DATE OF BURIAL 8/3 1921

ADDRESS

20 UNDERTAKER Jack Lewis 1411 E Balto

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 55849

REGISTERED NO.

D 55849

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2932 St. Paul St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Amos King

(a) RESIDENCE. NO. 2932 St. Paul St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma D. King

6 DATE OF BIRTH (month, day, and year) May 11" 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dealer in Scrape Iron & Metal for self

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montclair N. J.

PARENTS

10 NAME OF FATHER Theodore F. King

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Mary E. Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant (Address) Mrs. Emma D. King 2932 St. Paul St.

15 Filed AUG 3 1921 ROBERT B. ARMISTEAD Registrar Burial Permit Oled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2" 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8" 1920, to Aug 2" 1921, that I last saw him alive on Aug 2" 1921, and that death occurred, on the date stated above, at 9.50 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

About 3 hours (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? The Physicians signs

(Signed) Charles E. B., M. D.

Aug 3. 1921 (Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montclair, N.J.

DATE OF BURIAL Aug 5" 1921

ADDRESS 1003 W. Balto St.

20 UNDERTAKER Joseph B. Cook

CAUSE OF DEATH to be filled in plain ... See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55850

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55850

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3727 Foster Ave. ST.; No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Hart

(a) RESIDENCE. NO. 3727 Foster Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9 - 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store keeper.

(b) General nature of Industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael Hart.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Mikt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

11 Informant Margaret Hart. (Address) 3727 Foster Ave.

15 Filed AUG 3 - 1921 ROBERT S. [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to Aug. 1, 1921, that I last saw him alive on Aug. 1, 1921, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Cronin M. D.

Aug. 2, 1921 (Address) 2314 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Aug 4 1921

20 UNDERTAKER Lilly & Julier

ADDRESS 1038 W. Fay. St.

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Garoslav Hlubucek

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55851

CERTIFICATE OF DEATH.

D 55851

REGISTERED NO. C 79

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2201 Mura 1. ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Garoslav Hlubucek, JAROSLAV HLUBUCEK

(Residence in Baltimore: No. 2201 mura st. St. (yrs. 15 mos. dy.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word): Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1..... (Year)

7-AGE, 46 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work: baker (b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Bohemia

PARENTS.

10-NAME OF FATHER: Joseph Hlubucek

11-BIRTHPLACE OF FATHER (State or Country): Bohemia

12-MAIDEN NAME OF MOTHER: Marie Mazanec

13-BIRTHPLACE OF MOTHER (State or Country): Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hlubucek

(Address) 2201 Mura st

15- Filed ..... 1921 AUG 3 ..... Registrar.

Burial Permit Issued

CAUSE OF DEATH must be filled in plainly and completely. Every question must be answered or the word "unknown" written if the information cannot be obtained. Ditto marks are not sufficient. Be particular and give full information as to localities and dates. Every certificate must be signed and dated. Causes of death which may have existed for years should be dated back as accurately as possible. Consult the Table of Contributory Causes. Indefinite and unsatisfactory causes of death will be returned for correction. Cause of death must be certified to by a physician, if there was one in attendance during last illness; otherwise by the coroner. Midwives and undertakers are not authorized to certify to causes of death. Burial Permit will not be issued until certificate is properly filled out and signed. Violent deaths must be reported immediately to the Coroner. Deaths occurring in hospitals or institutions must be certified to by the physician in charge. Deaths occurring in penal institutions must be reported to the Coroner. Deaths occurring on vessels must be reported at the first port of arrival in the United States. Deaths occurring on trains must be reported in the county through which the train is passing when the death occurs. Deaths occurring while traveling must be reported in the county where the body is found. Deaths occurring in the open country must be reported in the county where the body is found. Deaths occurring in cities must be reported in the city where the death occurs. Deaths occurring in towns must be reported in the town where the death occurs. Deaths occurring in villages must be reported in the village where the death occurs. Deaths occurring in boroughs must be reported in the borough where the death occurs. Deaths occurring in townships must be reported in the township where the death occurs. Deaths occurring in districts must be reported in the district where the death occurs. Deaths occurring in wards must be reported in the ward where the death occurs. Deaths occurring in precincts must be reported in the precinct where the death occurs. Deaths occurring in parishes must be reported in the parish where the death occurs. Deaths occurring in counties must be reported in the county where the death occurs. Deaths occurring in states must be reported in the state where the death occurs. Deaths occurring in territories must be reported in the territory where the death occurs. Deaths occurring in districts must be reported in the district where the death occurs. Deaths occurring in wards must be reported in the ward where the death occurs. Deaths occurring in precincts must be reported in the precinct where the death occurs. Deaths occurring in parishes must be reported in the parish where the death occurs. Deaths occurring in counties must be reported in the county where the death occurs. Deaths occurring in states must be reported in the state where the death occurs. Deaths occurring in territories must be reported in the territory where the death occurs.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug ..... (Month) 1 ..... (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Heart disease

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... (Coroner) M. D.

8-1-21 (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rodeemer

DATE OF BURIAL, Aug 4, 1921

20-UNDERTAKER Frank Graefer Sons

ADDRESS 1406 Eutaw

Spec.—6-9-19—H. P. Co.—1000 Blks.

Vannie E. Nock

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55852

CERTIFICATE OF DEATH

D 55852

REGISTERED NO.

1-PLACE OF DEATH University Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. Lombard & Greene ST.; 4 WARD)

2-FULL NAME Vannie E. Nock

(a) RESIDENCE. NO. Christfield Md. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced (or) WIFE of L. S. Nock

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE — Years: 37 years; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General natore of Industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER [illegible] O. Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maggie Dize

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant L. S. Nock (Address) Christfield Md

15 Filed ....., 19 .... BOBBITT & ERCOLINE Burial Permit Clerk (Registrar)

AUG 3 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 2, 1921, that I last saw her alive on Aug 1, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic arterial hypertension
Chronic Interstitial nephritis
Chronic Myocardial insufficiency

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Crisfield Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical findings

(Signed) [illegible], M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Crisfield Md — DATE OF BURIAL: 8-3-21

20 UNDERTAKER: Harry C Banning & Son — ADDRESS 517 N. Schroeder St

TION is very important. See instructions

6-9-19—H. P. Co.—1000 Blks.

D 55853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55853

CERTIFICATE OF DEATH.

REGISTERED NO. 14 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 726 Reservoir (St.:) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Josepha Cissington

(a) RESIDENCE. NO. 726 Reservoir St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Single

5a If ~~married~~, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 19th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	63	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Sr B. Cissington

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER C. L. Everitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant (Address) Mrs. Thomas E. Pond 726 Reservoir

15 Filed AUG 3 — 1921 19 HENRY J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to August 3, 1921, that I last saw h— alive on August 2, 1921, and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. N. Morrison, M. D.

, 19 (Address) 1313 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Goldsborough M. C. — DATE OF BURIAL Aug 3 1921

20 UNDERTAKER Henry Parkin's Son & Co. — ADDRESS 2nd and Fremont

Spec.—6-9-19—H. P. Co.—1000 Bks.

Simmers ✓ D 55854

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55854

X30

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Joseph Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jakel Simmers

(a) RESIDENCE. (NO. Triumph's mill Road ST. Rossville Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of Magdelena Simmers

6 DATE OF BIRTH (month, day, and year) June 23/86

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35/12.	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur (Truck)

(b) General nature of industry, business, or establishment in which employed (or employer) 273

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James R. Simmers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Magdelena Simmers
(Address) 28 N. Clinton St.

15 Filed AUG 3 - 1921 [illegible] Registrar

CAUSE OF DEATH. ATTENTION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-2-1921.

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to Aug. 2, 1921.

that I last saw him alive on Aug. 2, 1921.

and that death occurred, on the date stated above, at 7 25 a m.

The CAUSE OF DEATH* was as follows:

Tuberculas Meningitis.

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) F. C. Marbut M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Aug 4 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

Spec.—6-9-1)—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55855

D 55855

CERTIFICATE OF DEATH.

REGISTERED NO. 1120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3209 Fleet ST.: (WARD) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine H. Hagie

(a) RESIDENCE. No. 3209 Fleet ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs 10 mos 11 ds. How long in U. S., if of foreign birth? 58 yrs 10 mos 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Henry Hagie

6 DATE OF BIRTH (month, day, and year): Sept 20 1862

7 AGE — Years: 58 Months: 10 Days: 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Foltz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Henry Hagie 3209 Fleet St.

15 AUG 3 - 1921

[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3d, 1921, to July 31, 1921, that I last saw h[illegible] alive on July 31, 1921, and that death occurred, on the date stated above, at 2 40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatic Apoplexy

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): apoplexy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urin

(Signed) [illegible] M. D.

Aug 1, 1921 (Address) 3309 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: Aug 3 1921

20 UNDERTAKER: Philip Hennig — ADDRESS 2016 Orleans

CAUSE OF DEATH is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

40 / D 55856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55856

CERTIFICATE OF DEATH.

1-PLACE OF DEATH * REGISTERED NO.....

CITY OF BALTIMORE: (No. 3. 4½ St Brooklyn 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Towns

(a) RESIDENCE. No. 3. 4½ St Brooklyn 2nd WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Towns

6 DATE OF BIRTH (month, day, and year) Mar 16 1873

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
48	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) other

(c) Name of employer home

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER H. Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Sarah Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Lizzie Hall

(Address) Bl. 4½ St Brooklyn Md.

15 Filed AUG 3 - 1921 19... [illegible] Registrar

Registrar's Record, Death Certificate

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25, 19 21, to Aug 2, 19 21, that I last saw h— alive on Aug 1, 19..., and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ex Laparotomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooks, M. D.

Aug 2, 1921 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 4 1921
20 UNDERTAKER John F Denny	ADDRESS 7.5 Light St

CAUSE OF DEATH. ATTENTION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Eating Watermelon & Cucumbers

Gene Peritonitis

Malignant Tumor of the Stomach

Spec.—6-9-19—H. P. Co.—1000 Bks.

Katherine Stivers

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55857

CERTIFICATE OF DEATH.

H V D 55857

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2625 Hafer ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Stivers

(a) RESIDENCE. NO. 2625 Hafer ST. 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. A. Stivers

6 DATE OF BIRTH (month, day, and year) Nov. 18-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John D. Kappauf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George A. Stivers (Address) 2625 Hafer St.

15 Filed AUG 3 - 1921 19 [redacted] REGISTER Health Department

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1921, to Aug 2, 1921, that I last saw h ex alive on Aug 2, 1921, and that death occurred, on the date stated above, at 3 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 11-20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R Amy Glassman, M. D.

Aug 3 1921 (Address) 2687 Mertens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug. 5 1921

20 UNDERTAKER George L. Schmidt & Bro ADDRESS 201 Fulton Ave

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55858

CERTIFICATE OF DEATH.

D 55858

REGISTERED NO. 28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 557 Baker ST., 14 WARD)

2-FULL NAME Robert Stanley

(a) RESIDENCE NO. 557 Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary V Stanley

6 DATE OF BIRTH (month, day, and year) 1860 ?

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brew of Lime

(b) General nature of industry, business, or establishment in which employed (or employer) Lime

(c) Name of employer Warthen & Son

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mary V Stanley (Address) 557 Baker St

15 Filed AUG 3 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1921

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1921, to Aug 1, 1921, that I last saw him alive on Aug 1, 1921, and that death occurred, on the date stated above, at 1130P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage of Lung (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E William Frey M. D.

(Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Aug 4 1921

20 UNDERTAKER Edw Ruggold — ADDRESS 1463 Carey

CAUSE OF DEATH. See instructions on back of sheet. INFORMATION is very important.

Hawthorne

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55859

CERTIFICATE OF DEATH.

169 D 55859

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1013 Vincent St ST.: 16 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Hawthorne
(Residence in Baltimore: No.) St.: 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 3 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, George Hawthorne

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Meade

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mamie Hawthorne
(Address) 1013 Vincent St

15-
Filed AUG 3 - 1921 ROBERT J. KRAUTH Registrar.

CAUSE OF DEATH to be filled in by physician. Omission of important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., Aug 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

Signed Chas. Paul Jones M. D.
(Coroner)
Aug 2 1921 (Address) 1500 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Lebanon Cem City — DATE OF BURIAL, Aug 3, 1921

20-UNDERTAKER Edward Ruggard — ADDRESS 1463 N. Carey St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

D 55860

1-PLACE OF DEATH Lombard & Greene

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and nnmber.)

2-FULL NAME Baby Kelbaugh

(a) RESIDENCE. NO. Phoenix Md ST. ..... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Infant

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31-1921

7 AGE Years ..... Months ..... Days ..... If LESS than 1 day, 2 hrs. and 35 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Howard Kelbaugh

11 BIRTHPLACE OF FATHER (city or town) Oleale (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Parrish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Maryland

11 Informant (Address) Elizabeth Kelbaugh (Mother) Phoenix Md

15 Filed AUG 3 - 1921 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1921

17 I HEREBY CERTIFY, that I attended deceased from July 31, 1921, to July 31, 1921, that I last saw her alive on July 31, 1921, and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity (36 wks. foetal)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wilmer Rees, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: AUG 3 19

20 UNDERTAKER: Commissioner Health

ADDRESS

CAUSE OF DEATH TION is very important. See instructions on back of

D 55861 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 55861

CERTIFICATE OF DEATH. 161

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Off Hanover St. Bridge. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J.H. Oswald Marling.

(Residence in Baltimore: No.) Hotel Altamont, Lanvale & Eutaw. St.: 5 yrs., ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. Do not know. (Month), 1 (Day), ... (Year)

7-AGE. about 60 yrs. ---- mos. ---- ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Physician.
(b) General nature of industry, business, or establishment in which employed (or employer): ✓

9-BIRTHPLACE, (State or Country). Canada.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W.S. Wright.

(Address) Hotel Altamont.

15- Aug 3 1921 Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1st. 1921. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the skull. Suicide.
By jumping from the Hanover St. Bridge.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)
Aug. 3rd. 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery
DATE OF BURIAL, Aug 4. 1921

20-UNDERTAKER John F. Denny
ADDRESS 715 Light St

CAUSE OF DEATH to be filled in by physician only. important. See instructions on back of certificate.

Stock—6-9-13—H. P. Co.—1000 Blks.

D 55862

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55862

CERTIFICATE OF DEATH.

5 138

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 East ST.: WARD)

2-FULL NAME Florence Johnson

(a) RESIDENCE. NO. 206 East ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	married

5a If married, widowed, or divorced (or) WIFE of Edward Johnson

6 DATE OF BIRTH (month, day, and year) March 3, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua Light

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Light

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant W. W. Gray

(Address) Johns Hopkins Hospital

15 Filed Aug 3 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1921, to Aug 2, 1921, that I last saw her alive on Aug 2, 1921, and that death occurred, on the date stated above, at 8.31 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism following spontaneous delivery.

Patient referred to S. Gilmore M.D. Coroner.

(duration) — yrs. — mos. 1/48 ds.

CONTRIBUTORY (Secondary) Pulmon embolism (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) E. L. Stone, M. D.

Aug 2, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel.	Aug 4th 1921
20 UNDERTAKER Leo G. Cook	ADDRESS 708 The Belvedere

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55863

CERTIFICATE OF DEATH

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2116 Mayer st ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME amelia Hall

(a) RESIDENCE NO. 2116 Mayer ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David C Hall

6 DATE OF BIRTH (month, day, and year): Mar 12 1879

7 AGE: Years 42 | Months 4 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George Duke Heart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Caroline Kinzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs Carrie Seibel 2205 Orleans st

15 Filed Aug 8 1921 Robert F. Harrison, Registrar

Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1921. to Aug 1 1921.

that I last saw h alive on Aug 1 1921. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

Chronic Dysentery

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Warfield M. D.

(Address) 1 E Read 3 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Aug 4 1921

20 UNDERTAKER: Jno Christian Miller

ADDRESS: 1337 Jeffers st

CAUSE OF DEATH. See instructions on back of this certificate. ATTENTION is very important.

G 8—1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Trumbo)

D 55864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55864

CERTIFICATE OF DEATH

REGISTERED NO. 105

1-PLACE OF DEATH Bayview Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6 ST.: 18 WARD)

2-FULL NAME Charles G. Trumbo.

(a) RESIDENCE. NO. 116 S. Schroeder ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or ~~WIFE of~~) Mrs. Chas. Trumbo.

6 DATE OF BIRTH (month, day and year) July 4 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69		30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS
10 NAME OF FATHER Charles Trumbo
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Charlotte Wilbourn
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bayview Hospital

15 Filed 3-1921 Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1921, to Aug 3, 1921.
that I last saw h im alive on Aug 2, 1921.
and that death occurred, on the date stated above, at 1.30 a.m.
The CAUSE OF DEATH* was as follows:

Acute Diarrhea + Enteritis

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown (duration) yrs. mos.
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical findings
(Signed) A. Goldsmith, M. D.
8/3, 1921 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Aug. 5, 1921

20 UNDERTAKER: Joseph B. Cook ADDRESS: 1103 W. Balto St.

TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55865

CERTIFICATE OF DEATH.

104 D 55865

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 n Dallas St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME napolian Perry

(Residence in Baltimore: No. 721 n Dallas St.; unknown yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, July (Month) ..... (Day), 1920 (Year)

7-AGE, 1 yrs. 1 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Charlotte, N. C.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Bill Perry

13-BIRTHPLACE OF MOTHER (State or Country), Charlotte N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Woodruff

(Address) 719 N. Dallas St.

15-

Filed AUG 4 1921 191.

Registrar.

important. See instructions on back of Certificate

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 3 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1921, to Aug 1 1921, that I saw h[illegible] alive on Aug 1 1921, and that death occurred, on the date stated above, at 4 am m.

The CAUSE OF DEATH* was as follows:

Ileo-colitis

Rachitis 1 year

(Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Rachitis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Edward Fisher M. D.

8-3 1921 (Address) 1612 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Aug 4, 1921

20-UNDERTAKER Thos J. G. Locke ADDRESS 1302 Jefferson

Connors.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 55866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55866

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Mercy Hospital ST.: 10 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Connors.

(a) RESIDENCE NO. 1104 East Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1857

7 AGE: Years 64 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Street Cleaner
(b) General nature of industry, business, or establishment in which employed (or employer) City
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER Unknown Connors
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mary E. Connors 1104 E Madison St

15 Filed AUG 4 - 1921 JOSEPH I. TRAUTH Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 1921 to Aug 3 1921 that I last saw h[illegible] alive on Aug 3 1921 and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage 36 hrs.
(duration) yrs. mos. dys.

CONTRIBUTORY (Secondary) Respiratory failure 12 hrs
(duration) yrs. mos. dys.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Signs & Symptoms

(Signed) John J. Coffey M. D.
Aug 4, 1921 (Address) McKay Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery
DATE OF BURIAL: Aug 6 1921
ADDRESS

20 UNDERTAKER: Henry Storck Sons 1301 E Eager St

ATTENTION is very important. See instructions on back.

Genesis Green. ✓

Spec.—1-10-21—M&T—1500 Bks.

148960
D 55867

HEALTH DEPARTMENT—CITY OF BALTIMORE

32 D 55867

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST., 14 WARD)

2-FULL NAME Genesis Green

(a) RESIDENCE NO. 2134 Division St. Balto. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 26. 12. 90

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	20	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER David Green.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Brooks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) John Hopkins Hospital Balto.

15 Filed AUG 4 - 1921 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from June 19 , 1921 , to Aug 1st , 1921 , that I last saw him alive on Aug 1st , 1921 , and that death occurred, on the date stated above, at 9.5 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of cervical spine. — Tbc of subcutaneous tissues.

abscess (duration) about 1 yrs mos ds.

CONTRIBUTORY (Secondary) Retro-pharyngeal abscess (duration) about 1 mos ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Animal inoculation

(Signed) Henry M. Thomas for M. D.

8-1. 1921 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ind Auburn Cem	July 4 1921
20 UNDERTAKER George T. A. Gibson	ADDRESS 513 Fayette St

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 001
63-
D 55868

CERTIFICATE OF DEATH.

D 55868

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 E Balto St ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arnold Caplan

(a) RESIDENCE. NO. 2108 E. Balto St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Caplan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lillie Dimbrosky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mr Charles Caplan
(Address) 210 E Balto St

15 AUG 4 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4/1921

17 I HEREBY CERTIFY, That I attended deceased from 8/2/1921, to 8/4/1921.
that I last saw him alive on 8/4/1921.
and that death occurred, on the date stated above, at 6, a m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Goldman M. D.

8/4, 1921 (Address) 2210 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Blair Rd.

DATE OF BURIAL Aug 4 1921

20 UNDERTAKER Jos L Jenson

ADDRESS 1127 E Balto St

TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55869

CERTIFICATE OF DEATH.

140 D 55869

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Mds., 56 WARD) 24

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Anderson

(a) RESIDENCE NO. US. Public Health Hosp. #56 Fort McHen WARD 35
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56 yrs	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosenbrock Registrar
(Address) US.PHS Hosp. #56 Ft McHenry Md

15 Filed AUG 4 1921 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1921, to August 3, 1921, that I last saw him alive on August 2, 1921, and that death occurred, on the date stated above, at 8'20 pm.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

April 26 1921 (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis chronic

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Herman R. Payne M. D.

Aug 3 1921 (Address) Senior Surgeon (R) US.PHS Hosp. #56 Ft McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Aug 4 1921

20 UNDERTAKER Sol Levinson

ADDRESS 1127 Eutaw St

CAUSE OF DEATH: ... TION is very important. See instructions on back of Certificate.

Spec.—1-10-21—M&T—1500 Bks.

Dr. Young.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55870

CERTIFICATE OF DEATH.

80 D 55870

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2200 Boston ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Zirckel

(a) RESIDENCE NO. 2200 Boston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lisette C. Zirckel

6 DATE OF BIRTH (month, day, and year) Aug. 29, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired 25 years

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Zirckel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hax

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry A. Zirckel

(Address) 2200 Boston St.

15 Filed AUG 4 - 1921 Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1921

17 I HEREBY CERTIFY, That I attended deceased from August 1st, 1921, to Aug. 2nd, 1921, that I last saw h.. alive on Aug. 2nd, 1921, and that death occurred, on the date stated above, at 7 45 P.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J. Young, M. D.

Aug 3, 1921 (Address) 1708 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug 5 1921

20 UNDERTAKER H. Sander & Sons

ADDRESS 1710 Eastern Ave.

CAUSE OF DEATH ... See instructions on back. ATTENTION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55871 ✓ D 55871

CERTIFICATE OF DEATH.

6 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2200 E. Balto ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph B. Kenney

(a) RESIDENCE NO. 2200 E. Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Kenney

6 DATE OF BIRTH (month, day, and year) Oct 24, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer B. & O. R.R. Co. Balto

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Capt Benj. F. Kenney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Lowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Elizabeth Kenney

(Address) 2200 E. Baltimore St

15 Filed AUG 4 - 1921 ROBERT J. KRAUTER Registrar

CAUSE OF DEATH. See instructions on back of this CERTIFICATE. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Aug. 2, 1921, that I last saw him alive on Aug. 1, 1921, and that death occurred, on the date stated above, at 3.50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene L. Pessagno M. D.

Aug. 3, 1921 (Address) 2314 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 4 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55872

CERTIFICATE OF DEATH.

151 D 55872

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 E Pratt ST.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Son John & Laura Steinmetz

(Residence in Baltimore: No. 2001 E Pratt St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Aug. 3rd, 1921 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 6 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, John Steinmetz

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Laura Wa. Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Steinmetz

(Address) 2001 E Pratt St

15-

Filed ..... 191..... REGISTRAR. Registrar.

AUG 4 - 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 3rd, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 3 1921, to Aug 3rd 1921, that I saw him alive on Aug 3 1921, and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

Premature birth of Seven & Half months Baby

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Devers M. D.

8-3-21, 191.. (Address) 2600 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, 1st Evangelical Cem. DATE OF BURIAL, Aug. 4, 1921.

20-UNDERTAKER L. Sander Sons ADDRESS 1710 Park Ave

important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55873

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 574 Hannaen alley ST.: 11 WARD)

2-FULL NAME Bertie O'Hill

(a) RESIDENCE. NO. 574 Hannaen alley ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Dom'l

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katie Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Daniel Easton (Address) 916 Pa ave

15 Filed AUG 4 - 1921 ROBERT J. BRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2d 1921

17 I HEREBY CERTIFY, That I attended deceased from July 26th, 1921, to Aug 2, 1921, that I last saw her alive on Aug 2, 1921, and that death occurred, on the date stated above, at 12-8 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Samuel A Bain, M. D.

, 19 (Address) 937 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 5-21
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa ave

TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

149782 D 55874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 55874

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hospital St., 4 WARD)

2-FULL NAME Jeremiah Harrison

(a) RESIDENCE No. 630 Josephine St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mary F. Thompson (mother)

6 DATE OF BIRTH (month, day, and year) Dec. 8, 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed AUG 4 - 1921 WEEKS : FRANTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1921, to Aug 3, 1921.

that I last saw him alive on Aug 3, 1921.

and that death occurred, on the date stated above, at 12.25 A.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) about 3 weeks.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? ~~not yet~~ - Yes

What test confirmed diagnosis? Physical Examination

(Signed) Henry M. Thomas Jr. M. D.

8-1, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Aug 6 1921

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Ea ave

CAUSE OF DEATH. See instructions on back. IMPORTANT. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 55875 HEALTH DEPARTMENT—CITY OF BALTIMORE

50 D 55875

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Samuel Lefkowitz

(a) RESIDENCE. NO. 937 Penn Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~~Married~~ Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) Aug 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) DH's

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Lefkowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Mrs Miller Baltimore

15 FILED AUG 4 - 1921, 19 ROBERT P. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1921, to Aug 3, 1921, that I last saw him alive on Aug 3, 1921, and that death occurred, on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH* was as follows: Diabetes Mellitus

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acedosis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. findings Sugar & Acetone

(Signed) John L. Edwards M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	8/4 1921
20 UNDERTAKER Jack Lewis 1414 E Balto	ADDRESS

TION is very important. See instructions on back.

Spec.—1-10-21—M&T—1500 Blks.

(See affadavit over)

D 55876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 55876

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2239 Madison Ave (St.) 13 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Beckerman

(a) RESIDENCE NO. 2239 Madison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis J Beckerman

6 DATE OF BIRTH (month, day, and year): October 1863

7 AGE: Years 58; Months —; Days —; If LESS than 1 day, hrs or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address): 1411 Eutaw St

15 Filed AUG 4 - 1921 ROBERT I. CARTER Registrar

Burial permit Oler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 4 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1921, to Aug 3, 1921,

that I last saw h/ alive on Aug 3, 1921,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis,

Cerebral Hemorrhage

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cerebral Hem, (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) Harry Linde, M. D.

, 19 (Address) 114 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehren Herring Run — DATE OF BURIAL: 8/4 1921

20 UNDERTAKER: Jack Lewis — ADDRESS: 1411 Eutaw St

CAUSE OF DEATH. See instructions on back of certificate. ATTENTION is very important.

REVISED UNIT
CERTIFI
[Approved by U. S. Cen

Statement of Occ
occupation is very
healthfulness of vari
question applies to
spective of age. For
or term on the fir
Farmer or *Planter*,
tect, Locomotive eng
fireman, etc. But in
trial employments,
kind of work and al
or industry, and the
vided for the latter
when needed. As e
mill; (a) Salesman,
Automobile factory)
form part of the s
"Laborer." "Forema
without more preci
Farm laborer. Labo
home, who are engag
only (not paid *Hou*
salary), may be en
or *At home*, and chi
At school or *At h*
report specifically th
in domestic service
Housemaid, etc. If
or given up on acco
state occupation at
from business, tha
Farmer (retired, 6
occupation whateve

Statement of Ca
DISEASE CAUSING DE
respect to time a
same accepted term
Cerebrospinal feve
"Epidemic cerebro
(avoid use of "C
port "Typhoid
Bronchopneumonia
indefinite); *Tuberculosis of lungs, miliary, p*
toneum, etc., *Carcinoma, Sarcoma*, etc., of_____
(name origin; "Cancer" is less definite; avoid use of

Personally appeared before me
and made affadavit that the given on De
55876 should be 64 years instead of 58.

Jack
Rec
Notary.
Jan 1, 1929

Measles;
: disease
ntributory
d not be
s (disease
s (second-
r terminal
' (merely
na," "Con-
lle," etc.),
"Hemor-
" "Shock,"
ite disease
qualify all
arriage, as
eritonitis,"
ation was
MEANS OF
ICIDE, or
ossible to
tal drown-
: Revolver
rbolic acid
injury, as
g., *sepsis*,
"Contribu-
f cause of
nclature of

Baltimore, Md. August 5, 1928

Mr. Jacob Lewis

Death Certificate

58.

Louis

MENTS

Bickie Lerner.

D 55877

55877

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Station 19

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Train 173 Pa. R.R. Key Union St. 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bickie Lerner

(Residence in Baltimore: No. 2107 E. Balto St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Wid

6-DATE OF BIRTH, ... (Month) ..... (Day) 1856 (Year)

7-AGE, 65 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work ..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or Country), Russia

PARENTS.

10-NAME OF FATHER, M. Rubin

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Lerner

13-BIRTHPLACE OF MOTHER (State or Country), Lerner.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lerner

(Address) 2403 E. Balto

15 AUG 4 - 1921 Filed ....., 191.... [redacted] Registrar

Burial Permit 070

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Acute Dilation Heart
Did Suddenly
(b) Pneumonia (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner)

Aug 3, 1921 (Address) ..... 1437 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mehren Woodlawn	8-4, 1921
20-UNDERTAKER	ADDRESS
Jack Levin	1411 E Balto St

CAUSE OF DEATH. See instructions on back of certificate. Important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55878

CERTIFICATE OF DEATH.

64 D 55878

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 319 E Cross ST.: 74 WARD)

2-FULL NAME William Alexander Nash

(a) RESIDENCE. NO. 319 E Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma S. Nash

6 DATE OF BIRTH (month, day, and year) Jan 29 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper D H S

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods - Notions

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James A Nash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Emma S. Nash

(Address) 319 E Cross St

15 Date AUG 4 1921 Registrar

CAUSE OF DEATH. See instructions on back. IMPORTANT. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1921

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1921, to Aug 3, 1921, that I last saw him alive on Aug 3, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys.

(Signed) Wm L Stifler, M. D.

8/4, 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery

DATE OF BURIAL Aug 6 1921

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55879 HEALTH DEPARTMENT—CITY OF BALTIMORE 55879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital 176 REGISTERED NO.

CITY OF BALTIMORE: (NO. Fayette & Calhoun ST.; 20th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles N Meyers

(a) RESIDENCE. NO. 914 Columbia Ave ST., WARD. 21st

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Sarah Wolf.

6 DATE OF BIRTH (month, day, and year) Aug 13-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68	~~11~~ 11	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 113

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany. Ostfriesland.

PARENTS

10 NAME OF FATHER Adolph Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Eli H. Meyers

(Address) 914 Columbia Ave

15 Filed AUG 4 - 1921 . 19 ROBERT J. KRAUSE Postal Permit Clerk

TION is very important. See instructions on Back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20 . 1921 . to Aug. 4 . 1921 .

that I last saw him alive on Aug. 4 . 1921 .

and that death occurred, on the date stated above, at 2.25a . m.

The CAUSE OF DEATH* was as follows:

Prostatic Enlargement.

Gangrene of Right Great Toe.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Retention of Urine

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? YES Date of June 26.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard M Bubert . M. D.

. 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Beth Shalom Cemetery	Aug 5 1921

20 UNDERTAKER F B Weyforth ADDRESS 2336 Fred'k Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55880

CERTIFICATE OF DEATH.

105 D 55880

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 Saint St., 22 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Ross

(Residence in Baltimore: No. 317 Druid St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Black	Married

6-DATE OF BIRTH, June (Month) 6 (Day), 1? (Year)

7-AGE, unknown ..53.. yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Williams

(Address) 0312 Druid St.

15- AUG 4 - 1921

Filed ....., 191.... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20 1921, to Aug 2 1921, that I saw him alive on Aug 2 1921 and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows:

(a) ..... Cancer

..... (Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. ? ds.

(Signed) ..... M. D.

Aug. 3, 1921. (Address) 109 W. Lee St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Aug 4, 1921
20-UNDERTAKER	ADDRESS
J. E. Brown and Son	1011 W. Montgomery

important. See instructions on back of certificate.

Florence Lieszman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Union Station ST.: 19 WARD)

2-FULL NAME Mrs Florence Lieszman

(Residence in Baltimore: No. 1300 W Lexington St.)

REGISTERED No. C 40

D 55881

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

22 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ..., 1 (Month) (Day) (Year)

7-AGE. 54 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE. (State or Country), Pa.

PARENTS.

10-NAME OF FATHER. Jno. G. Duke.

11-BIRTHPLACE OF FATHER (State or Country). Pa.

12-MAIDEN NAME OF MOTHER. Lydia Dubrel

13-BIRTHPLACE OF MOTHER (State or Country). Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J. Duke

(Address) Bayonne N. J.

Filed AUG 4 - 1921 191.. ROBERT P. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 2, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer stomach
+ Liver
Gall Bladder (Duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Weakness (Duration) ..yrs. ..mos. ..ds.

(Signed) W. H. Riley (Coroner.) M. D.

Aug 3, 1921 (Address) 1627 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Carlisle Pa. DATE OF BURIAL, 8-5, 1921

20-UNDERTAKER Wm Chas A G Rehkopf & Son Eutaw Ave

CAUSE OF DEATH in plain terms, and important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55882

CERTIFICATE OF DEATH.

15-28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 Friendsbury St ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Abicht

(a) RESIDENCE. NO. 1637 Friendsbury St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	wht	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula Abicht

6 DATE OF BIRTH (month, day, and year) Sept 16 th 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer C. D. Kenny Baltimore Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Charles Abicht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Voigt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lula Abicht wife

(Address) 1637 Friendsbury St

15 AUG 4 - 1924 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1924

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1924, to Aug 3, 1924, that I last saw him alive on Aug 3, 1924, and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Acute Pneumonic Phtysis)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. C. Lloyd M. D

, 19 (Address) 22 32 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 8-5 1924

20 UNDERTAKER Mrs Chas A. G. Rohde — ADDRESS. N Carlington Ave

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

) 55883 D 55883

CERTIFICATE OF DEATH.

16 80

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1123 Harlem ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Hallwig

(a) RESIDENCE. No. 1123 Harlem ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Hallwig

6 DATE OF BIRTH (month, day, and year): March 20 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Artists 001

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: August Hallwig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm. Hallwig (Address) 1123 Harlem ave

AUG 4 1921

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 3d 1921

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1921, to Aug 3d, 1921, that I last saw him alive on Aug 3d, 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

one hour

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis Interstitial (duration) 5 yrs. x mos. x ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? x Date of x

Was there an autopsy? x

What test confirmed diagnosis? Albumen in urine

(Signed) V Van Williams, M. D.

, 19 (Address) 601 N Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	8-5 1921

20 UNDERTAKER: Mrs. Chas E Roike & Co ADDRESS: Mulberry & Arlington Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Burial Permit Clerk

(Wolf Potts)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55884 D 55884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C. 79

CITY OF BALTIMORE (No. 2300 Tioga Place St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wolf Potts

(Residence in Baltimore: No. 2300 Tioga Place St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED: Widower (Write the word.)

6-DATE OF BIRTH: Unknown (Month) (Day), 1853 (Year)

7-AGE: 68 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Victor Potts

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Baltimore

15- Filed AUG 4 - 1921, 191.... ROBERT J. KRAUSE Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 4 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. Hennessy M. D. (Coroner.)

Aug. 4, 1921. (Address) 2502 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Hebrew Mt. Rd. DATE OF BURIAL, Aug 6, 1921

20-UNDERTAKER: Jack Lewis ADDRESS 1411 E. Balto St

CAUSE OF DEATH. See instructions on back of certificate. Important.

Spec.—6-9-19—H. P. Co.—100 Bks.

(Arthur Hennaut)

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D 55885

CERTIFICATE OF DEATH.

D 55885

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. New City Hospital, Bay (St.) 26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Hennaut

(a) RESIDENCE. No. ..... St., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 at least ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records New City Hospital

15 Filed AUG 4 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23 1909 to Aug. 2 1921 that I last saw h in alive on Aug 2 1921 and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Clyde McNeill M. D.

8/3/1921 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Aug 5/21 19

20 UNDERTAKER Wm. Cook

ADDRESS 502 E. North

CAUSE OF DEATH in plain ... See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55886

D 55886 CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Boags

(a) RESIDENCE. No. 911 McCulloh st. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Boags

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Milton Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Frances Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) M. T. H.

15 Filed AUG 4 - 1921 . 19 ROBERT J. BRAUTIGAM Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5 . 19 21, to August 1 . 1921 .

that I last saw h 0 Falive on August 1 . 1921 .

and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray.

(Signed) Clyde McNeil, M. D.

8-2-21. (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

UNIVERSITY OF MARYLAND. AUG 5 1921

20 UNDERTAKER — ADDRESS

Commissioner of Health,

By Wm. F. WOODALL

CAUSE OF DEATH: This information is required in the interest of the living, and is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55887 — 151 — D 55887

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Bidder Sellman Sand. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2724 St Paul's

2-FULL NAME Fetus Atkins

(a) RESIDENCE. NO. Monumental, 2nd St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer 000

9 BIRTHPLACE (city or town) (State or country) Bidder, Sellman Hosp.

PARENTS

10 NAME OF FATHER Thomas C. Atkins

11 BIRTHPLACE OF FATHER (city or town) Fredericksburg (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna L. Hammer

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 4 - 1921 ROBERT P. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1921

17 I HEREBY CERTIFY, That I attended deceased from — . 19 — . to Aug 2. 19 21.

that I last saw h alive on Aug 2, 19 21.

and that death occurred, on the date stated above, at 02 Hour

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) — yrs. — mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Vernon H Condon M. D.

, 19 (Address) 750 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL

20 UNDERTAKER Commissioner Health, ADDRESS 1921

Per. Wm. E. WOODAL. AUG 5

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be stated. Exact statement of date of birth should be properly classified. Exact statement of occupation may be CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

WLADYSLAW PIWONSKI

D 55888

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55888

CERTIFICATE OF DEATH.

1-PLACE OF DEATH. CITY OF BALTIMORE (No. Brooks Packing Co St: Fort Fells. WARD) REGISTERED No. C 181

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wladyslaw Piwonski

(Residence in Baltimore: No. 1526 Thames. St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Not Known, 1 ..... (Month) (Day) (Year)

7-AGE, ... 40 yrs. 0 mos. 0 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work ..... Laborer (h) General nature of industry, business, or establishment in which employed (or employer) ..... Packing House

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Joseph Piwonski

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antonia Piwonski

(Address) 1526 Thames St.

15-

Filed ..... 191.....

Robert P. Harrison,

Burial Permit Clerk. Registrar.

G 4 - 1921

CAUSE OF DEATH ... important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug. 2, 191.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) and that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electric Shock.

..... 15 Min.

..... (Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Accident

..... (Duration) yrs. mos. da.

(Signed) E. L. Blake M. D.

(Coroner)

Aug 2 191 (Address) 1463 E. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Aug 5, 1921

20-UNDERTAKER William Galloway — ADDRESS 118 Eastern

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55889

D 55889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amos Hollinger

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28th WARD. Columbia Pa.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs Hollinger

6 DATE OF BIRTH (month, day, and year) [illegible] 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 186

(b) General nature of industry, business, or establishment in which employed (or employer) Own business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Columbia Pa

PARENTS

10 NAME OF FATHER Henry Hollinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Katie Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant (Address) Records of Mt State Retreat Mt Hope Retreat

15 4-1921 Robert P. Harrison, Registrar

Dental Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2d, 1921, to Aug 4th, 1921, that I last saw h[illegible] alive on Aug 4th, 1921, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Paresis (Luetic)

abt (duration) yrs. 6 or 8 mos. ds.

CONTRIBUTORY (Secondary) Paretic Mania

abt (duration) yrs. 6 or 8 mos. 0 ds.

18 Where was disease contracted if not at place of death? Columbia Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? — W. Test (4+)

(Signed) Frank J. Flannery, M. D.

Aug 4, 1921 (Address) for Frank J. Flannery.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Columbia Pa.	Aug 4 1921
20 UNDERTAKER John J. Denny	ADDRESS 7.5 Light St

CAUSES OF DEATH. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Julia Manley)

D 55890

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55890

CERTIFICATE OF DEATH.

150

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 825 N. Crofford ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Manley

(a) RESIDENCE. NO. 825 N Crofford ST., WARD.

(Usual place of abode.) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	W.	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of — single

6 DATE OF BIRTH (month, day, and year) 8—4—21

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or ... min.
Two Months				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Herbert Manley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Julia Stack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Henry (Address) 825 N Mount St

15 Filed Robert P. Harrison, Registrar

8-4-1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 4 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-4-1921 to 8-4-1921

that I last saw him alive on 8-4-1921

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? .....

What test confirmed diagnosis? Autopsy

(Signed) Mat Cregg M.D.

4 1921 (Address) 700 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	8-5-1921
20 UNDERTAKER Frank Leach & Son	ADDRESS 1906 Eshelman

TION is very important. See instructions on back of certificate.

D 55891

√D 55891

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 Belair Rd. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F. Alexander

(a) RESIDENCE. NO. 1313 Belair Rd. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Strife yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. 6 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 31. 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James M. Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Blanche Wolheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Jas. M. Alexander 1313 Belair Road

15 [illegible] 4-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1921 to Aug. 3, 1921.

that I last saw him alive on Aug. 3, 1921.

and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Whooping Cough—

(duration) About yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Convulsions—

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Symptomatology

(Signed) Wm. H. Tannebaker M. D.

19 (Address) 1209 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Aug 5th 10 a.m. 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

TION is very important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55892

D 55892

CERTIFICATE OF DEATH.

104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 McCulloh ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wilson

(Residence in Baltimore: No. 1107 McCulloh St.; 1 yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Oct. (Month) 19 (Day), 1919 (Year)

7-AGE, 1 yrs. 10 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Jack McCoy

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Eugenia Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugenia Wilson

(Address) 1107 McCulloh St.

15-

Filed Aug 19 21 Robert P. Harrison Registrar.

8-4-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 4 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5/2 1921, to 8-4 1921, that I saw her alive on 8-3 1921, and that death occurred, on the date stated above, at 12.0 A.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) "Summer Complaint"

(Duration) yrs. mos. 10 ds.

(Signed) H. McPaul M. D.

8-4-1921 (Address) 1126 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Aug. 5., 1921

20-UNDERTAKER Felix B. Pyz

ADDRESS 1022 Melbourne Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55893

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55893

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1300 Morling Ave. ST.: 13 (WARD)

2-FULL NAME Alan Parker Stockdale

(a) RESIDENCE. NO. 1300 Morling Ave. ST., 13 WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Feb. 21-1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Wm. T. Stockdale

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER: Mattie C. Belt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Wm. T. Stockdale 1300 Morling Ave

15 Filed 4-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to Aug 3, 1921.

that I last saw h[illegible] alive on Aug. 3, 1921.

and that death occurred, on the date stated above, at 305 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary): Perforation - Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Widals

(Signed) Robert C. Huff, M. D.

8/4, 1921 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Reisterstown M. E. Cemetery — DATE OF BURIAL: Aug. 5 1921

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 363 Pulaski Rd.

TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

D 55894

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55894

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 Prospect Ave ST., 27th WARD) 29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Joseph Beam

(a) RESIDENCE NO. 119 Prospect Ave ST., 27th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Mar. 25 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William R. Beam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER Mary F. Teal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co. Md.

14 Informant Mrs. W. R. Beam

(Address) 119 Prospect Ave

15 Filed 8-4 19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-2 1924

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1914, to Aug-1, 1924, that I last saw him alive on Aug-1, 1924 and that death occurred, on the date stated above, at 4-05 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Endocarditis due to Influenza Pneumonia Dec. 1919. Dilatation of Heart (duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Progressive Muscular Dystrophy (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Gibson Porter, M. D.

8/2 1924 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Aug 6 19 24
20 UNDERTAKER	ADDRESS
Chenoweth Son	Chestnut ave

CAUSE OF DEATH should be plainly stated. Use terms that will convey definite information to others. Indefinite terms, such as "Heart Failure," "Exhaustion," "Old Age," "Infirmities of Old Age," "Senility," "Natural Causes," "Pneumonia," "Tuberculosis," "Cancer," "Stroke," "Fever," "Septicemia," "Blood Poisoning," "Uremia," "Convulsions," "Hemorrhage," "Meningitis," "Abscess," "Childbirth," "Miscarriage," "Accident," "Suicide," "Homicide," "Drowning," "Found Dead," "Burns," "Fracture," "Concussion," "Internal Injuries," "Shock," "Asphyxia," "Coma," "Unknown," "Unattended," "Not Known," "Not Attended," "Not Attended by Physician," "Not Attended by Physician Since," "Not Attended by Physician Since Last Visit," "Not Attended by Physician Since Last Visit Which Was," "Not Attended by Physician Since Last Visit Which Was Before," "Not Attended by Physician Since Last Visit Which Was Before Death," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated Above," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated Above, At," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated Above, At ....m.," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated Above, At ....m., The," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated Above, At ....m., The CAUSE," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated Above, At ....m., The CAUSE OF," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated Above, At ....m., The CAUSE OF DEATH," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated Above, At ....m., The CAUSE OF DEATH* was," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated Above, At ....m., The CAUSE OF DEATH* was as," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated Above, At ....m., The CAUSE OF DEATH* was as follows," "Not Attended by Physician Since Last Visit Which Was Before Death Which Occurred On The Date Stated Above, At ....m., The CAUSE OF DEATH* was as follows:

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55895

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55895

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 787 St. Peter ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias Claude Houck.

(a) RESIDENCE. NO. 787 St. Peter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed or divorced HUSBAND of ~~(or) WIFE~~ of Ella A. Houck.

6 DATE OF BIRTH (month, day, and year) Aug. 9. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Wm J. Houck.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary F. Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth Williams

(Address) 3611 Chestnut Ave

15 Filed Robert P. Harrison, Registrar

4-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1920, to Aug 4, 1921,

that I last saw him alive on Aug 3, 1921,

and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) Hrs 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evd.

(Signed) Bernard J Seng, M. D.

8/4/1921 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Patapsco Md	Aug 7 1921

20 UNDERTAKER ADDRESS

Chenoweth & Son Chestnut Ave

TION is very important. See instructions on back of certificate.

Akelis or Akircevicus

D 55896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

500 D 55896

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

REGISTERED No. C

2-FULL NAME Peter Akelis. or Akircevicus

(Residence in Baltimore: No. 210 W. Camden St. St.: 18 yrs., ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH. Do not know, (Month) (Day) 1 (Year)

7-AGE. 35 yrs. 0 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer. 40
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Lithuania.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Grenevickis.

(Address) 429 S. Paca St.

15- [illegible] 191...

AUG 5 - 1921

(Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 2nd. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nebhritis
(Alcoholism)
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D. (Coroner)

Aug 4th, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus DATE OF BURIAL, Aug 5, 1921

20-UNDERTAKER John Grebliunas ADDRESS 426 S Paca St

CAUSE OF DEATH to be filled in plainly and important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55897 — 152 D 55897 — REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Scruggs

(a) RESIDENCE. NO. 1733 Eastland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	B	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 1 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 10 min.
	✓	✓	✓	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ✓ 100
(b) General nature of Industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Scruggs
11 BIRTHPLACE OF FATHER (city or town) —
(State or country) Va
12 MAIDEN NAME OF MOTHER Malinda Scruggs
13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Va

14 Informant Dr. E. L. Stone
(Address) J. H. H.

15 Filed AUG 5 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/1 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/1, 1921, to 8/1, 1921,
that I last saw him alive on 8/1, 1921,
and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Fetal asphyxia - prolapsed cord.
Trauma - operative delivery.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY ✓
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of ✓
Was there an autopsy? ✓
What test confirmed diagnosis? ✓

(Signed) E. L. Stone, M. D.
8/3, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS AUG 4 - 1921

Commissioner Health.

Burial permit Given

18395

CAUTION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55898

CERTIFICATE OF DEATH

D 55898

1-PLACE OF DEATH {Rosanna Bushing}

CITY OF BALTIMORE: (No. 239 So Fifth ST.: (WARD) 16 92

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosanna Bushing

(a) RESIDENCE. NO. 234 So Fifth ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Bushing

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	None		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer) Home wife

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Thomas Bushing

(Address) 234 So Fifth St

15 Filed AUG 5 - 1921 19 ROBERT F. KRAUTZ Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6 1921, to August 4, 1921

that I last saw her alive on August 4, 1921

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Chronic Brights Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Senile Debility

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

(Address)

•State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Darlington Cem. Darlington Md

DATE OF BURIAL Aug. 6th 1921

20 UNDERTAKER Lilly & Zile

ADDRESS 403 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PROFESSION OR OCCUPATION should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificate. See instructions on back of certificate. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

14786

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55899 ✓

D 55899

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 18 WARD)

2-FULL NAME James Wm Sickles

(a) RESIDENCE NO. 1101 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year) Mar- 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Sickles

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York

12 MAIDEN NAME OF MOTHER Genevieve Thalheimer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed AUG 5 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1921, to Aug. 3, 1921, that I last saw he alive on August 3, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery).

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/5/21

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) W. R. Dawson, M. D.

8-4-21 19 (Address) 1014

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Federal

DATE OF BURIAL Aug 5 1921

20 UNDERTAKER Wm Cook

ADDRESS 508 North

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55900

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hospital ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Scardina; N

(a) RESIDENCE. No. 133 W. Barden ST.. WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 6. 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15		29	

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work Box Factory 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Joseph Scardina

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Antonia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) South Balto Gen. Hospital. 1213 Light St. Balto Md

15 Filed AUG 5 - 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 . 1921 . to Aug 4 . 1921 .
that I last saw her alive on Aug 4 . 1921 .
and that death occurred, on the date stated above, at 4.30 a. m.
The CAUSE OF DEATH* was as follows: Septicemia (Streptococcus)
Acholitis OVER

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? Yes Date of 8-3-21
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) R. W. Johnson M. D.
. 19 (Address) South Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincents Cem

DATE OF BURIAL: 8/6 1921

20 UNDERTAKER: J. H. Lakey & Sons

ADDRESS: 31 E. Eighty

TION is very important. See instructions on back of

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 55901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55901

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 126 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Burk Sykes

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER David Sykes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER May Jane Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed AUG 5 1921 ROBERT J. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2 1921

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1921, to August 2, 1921, that I last saw him alive on August 2, 1921, and that death occurred, on the date stated above, at 11:15 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hemiplegia (thrombotic)

(duration) yrs. mos. 1 4 ds.

18 Where was disease contracted if not at place of death? ~~Unknown~~ ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

8/3/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND.

DATE OF BURIAL AUG 5 1921 19

20 UNDERTAKER ADDRESS

Commissioner Health.

TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

149751 D 55902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 55902

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hospital ST., 9 WARD)

2-FULL NAME Doris Bennett.

(a) RESIDENCE NO. 1134 Longwood Street. 16 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~Five~~ Life mos. ~~do.~~ How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Mr. Harold Bennett 1134 Longwood Street

6 DATE OF BIRTH (month, day, and year) Dec. 29, 1920.

7 AGE — Years | 7 Months | 5 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: Harold Bennett.

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Ida Warrip.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Johns Hopkins Hospital Records (Address)

15 Filed AUG 5 — 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to Aug 3, 1921, that I last saw her alive on Aug 3, 1921, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

8-3 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Aug 5 1921

20 UNDERTAKER: Geo Lenibach & Son — ADDRESS: 687 W Pratt.

Burial Permit: Clerk

CAUSE OF DEATH to plain terms. See instructions on back of certificates. TION is very important.

D 55903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55903

CERTIFICATE OF DEATH.

REGISTERED No. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Stickel

(Residence in Baltimore: No. 507 S. Fremont ave St.; Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, June (Month) 20 (Day), 1900 (Year)

7-AGE. 21 yrs. 1 mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Md. C. R.R.

9-BIRTHPLACE. (State or Country). Balto. City.

PARENTS.

10-NAME OF FATHER. Jacob Stickel

11-BIRTHPLACE OF FATHER (State or Country). Balto. City

12-MAIDEN NAME OF MOTHER Theresa Rund

13-BIRTHPLACE OF MOTHER (State or Country). Balto. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Stickel

(Address) 507 S. Fremont ave

15- ROBERT J. KRAUTH

Filed AUG 5 - 1921 Registrar.

CAUSE OF DEATH to be plain terms, so important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 3 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Surgical operation

Badly lacerated thigh

Result of accident

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Probably Pyaemia

(Duration) yrs. mos. ds.

(Signed) Jno. M. Hruban M. D. (Coroner)

Aug 5, 1921. (Address) 710 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL, Aug 6, 1921

20-UNDERTAKER Jno Leinbacher — ADDRESS 641 W Lanvale St

Spec.—5-19-13—M. & T.—500 Bks.

D 55904

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

D 55904

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Pimlico Road N of Rogers ave ST.; 27 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth B. Oldson

(Residence in Baltimore: No. Old Pimlico Road near Rogers Ave St.; ....yrs., mos. 3½ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, W.

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) S.

6-DATE OF BIRTH, July 31st (Month) (Day), 1921 (Year)

7-AGE, ...yrs. mos. 3½ ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) Infant

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Clarence E Oldson

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Eliza B. Wise

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Oldson

(Address) Old Pimlico Road

15- Filed AUG 5 - 1921, 191.... ROBERT S KRAUTER Clerk
Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, aug (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from aug 1 3 AM 1921, to aug 3 6 PM 1921, that I saw her alive on aug 3 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency + general ~~Marasmus~~ debility due to premature birth (7th month)

(Duration) ....yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Lack of development

(Duration) ....yrs. mos. ....ds.

(Signed) A R Wartz M. D.

aug 5, 1921 (Address) 865 N. 36th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem't

DATE OF BURIAL, Aug 6th, 1921

20-UNDERTAKER Leitch & Fore

ADDRESS 1725 W Lafayette Ave

Cross out words not important. See instructions on back of certificate.

D 55905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55905

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Patapsco River Hospital St.; Ward) REGISTERED No. C 169

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Philip Charles Mueller

(Residence in Baltimore: No. 29 Quick Ave. Gardenville St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, June 8-1896, 1 (Month) (Day) (Year)

7-AGE, 25 yrs. 1 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Capenter 015

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. George A.Mueller

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Mary E.Hornan

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G.A.Mueller
(Address) 29 Quick Ave.Gardenville

15- Filed AUG 5 - 1921, 191... Burial permit issued
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 2, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc. Drowning

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ... yrs. ... mos. ... ds.

(Signed) C. E. Radcliffe M. D. (Coroner.)

Aug 4 1921 (Address) 143 E. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Most Holy Redeemer	8/6, 1921
20-UNDERTAKER	ADDRESS
Chas. F. Evans & Son	118 W. Mt. Royal

CAUSE OF DEATH must be plainly written. Every question must be answered if important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Matilda Clark

D 55906

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓091

104 D 55906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2331 Ashland ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Clark

(a) RESIDENCE. No 2331 Ashland ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 6-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Glenn Blank

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Kuchar

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country)

14 Informant Mary Kuchar (Address) 248 N. Port st

15 Filed AUG 5 - 1921 [illegible] Registrar

Serial No. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 4 1921

17 I HEREBY CERTIFY, That I attended deceased from aug 1, 1921 to aug 4, 1921

that I last saw h[illegible] alive on aug 4, 1921

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Gen Sepsis acute

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Tonsilitis

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Mal Sa M. D.

1921 (Address) 800 N Port st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug 6 1921
20 UNDERTAKER	ADDRESS
Francis Brach & Son	190 Ashland

CAUSE OF DEATH. TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55907

D 55907

CERTIFICATE OF DEATH.

91-678

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 Jordan ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Edward Cooper

(Residence in Baltimore: No. 923 Jordan St. St.; 1 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH, March 8 (Month) (Day), 1920 (Year)

7-AGE, 1 yrs. 4 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Charles Cooper

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Florance Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Cooper

(Address) 923 Jordan St.

15-

Filed..... Robert P. Harrison..... Registrar.

AUG 5 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 28 1921, to Aug 2 1921, that I saw h[illegible] alive on Aug 2 1921, and that death occurred, on the date stated above, at 2.15 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Arteriosclerosis

(Duration) ..... yrs. mos. 2 ds.

(Signed) Howard A. Warner M. D.

Aug. 4, 1921. (Address) 2604 Harford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 11 mos. ds. In the State ..... yrs. 11 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 923 Jordan St.

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Aug. 5, 1921

20-UNDERTAKER David Taylor

ADDRESS 916 Pa Ave

important. See instructions on back of certificate.

(Foard)

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55908

CERTIFICATE OF DEATH.

1524 D 55908

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 Battery Ave ST.; 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Foard.

(a) RESIDENCE. No. 1132 Battery Ave ST.; ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Foard.

6 DATE OF BIRTH (month, day, and year) Sept. 19th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ship Carter

(b) General nature of industry, business, or establishment in which employed (or employer): Balto Dry Dock Co

(c) Name of employer: Harford County

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: H. C. Foard

(Address): 1132 Battery Ave

15 Filed ..... 19 ..... Registrar

Robert P. Harrison

Burial Permit Clerk.

G5 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 1921, to Aug 4 1921, that I last saw him alive on Aug 4 1921, and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Asthma Bronchitis, (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) General weakness due to old age (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm E Stifler, M. D.

8/5, 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 8 1921
UNDERTAKER D. Gen McCurdy	ADDRESS 1808 Eutaw Ave

mation should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55909

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 55909

REGISTERED NO. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 117 N. Carrollton ave St.; 18 WARD)

2-FULL NAME Dr. Horace P. Haddock

(Residence in Baltimore: No. 117 N. Carrollton ave St.; 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: July 8, 1884 (Month) (Day) (Year)

7-AGE: 37 yrs. 0 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10-NAME OF FATHER: Thomas Haddock

11-BIRTHPLACE OF FATHER (State or country): Philadelphia, Pa

12-MAIDEN NAME OF MOTHER: Ella Pledger

13-BIRTHPLACE OF MOTHER (State or country): Richmond, Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Virginia Hendricks

(Address) 117 N. Carrollton Ave

15. Robert P. Harrison, (Permit Clerk.) REGISTRAR

1921 Burial Permit 191

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Aug. 5, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to Aug 4, 1921, that I saw him alive on Aug. 4, 1921, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) yrs. mos. 7 ds

Contributory (SECONDARY) Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

(Signed) John C. O'Neill, M. D.

Aug 5 1921 (Address) 827 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park Cem

DATE OF BURIAL: Aug. 8, 1921

20-UNDERTAKER: Geo. J. Smith

ADDRESS: W. Saratoga St

N. B.-Every item of information must be given so that it may be properly classified. Exact statement of OCCUPATION required, and state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. This is very important.

G 5

Spec.—8-24-14—M. & T.—2000 Bks.

D 55910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55910

CERTIFICATE OF DEATH.

REGISTERED NO. C 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 Poplar Grove St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Spedden

(Residence in Baltimore: No. 1201 Poplar Grove St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	widower

6-DATE OF BIRTH, Aug. (Month) 12 (Day), 1846 (Year)

7-AGE, 74 yrs. 11 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Grocer
(b) General nature of industry, business, or establishment in which employed (or employer): Commission Merchant 034

9-BIRTHPLACE, (State or Country), Dorchester Co. Md.

PARENTS.

10-NAME OF FATHER, Robert Spedden.

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co. Md.

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country), Dorchester Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest R. Spedden

(Address) 1201 Poplar Grove St

15-

Filed Aug. 5, 1921 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1921, to Aug 4 1921, that I saw h[illegible] alive on Aug 4 1921, and that death occurred, on the date stated above, at 7:20 p.m.

The CAUSE OF DEATH* was as follows: Carcinoma (primary) of the Pancreas

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph N Zeiler M. D.

8/5/21, 191.. (Address) 1013 Poplar Grove St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cambridge Md	Aug. 6, 1921
20-UNDERTAKER Geo J Smith	ADDRESS 1000 W Fayette St

important. See instructions on back of certificate.

G 5 - 1921

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55911 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55911

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 344 S. Vincent St. ST.: 19 WARD)

2-FULL NAME Annie E. Redlin

(a) RESIDENCE. NO. 344 S. Vincent St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of John Redlin

6 DATE OF BIRTH (month, day, and year) Oct. 29" 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) M Germany

PARENTS

10 NAME OF FATHER Mr. Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Mary F. Fauble
(Address) 344 S. Vincent St.

15 Filed AUG 5 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3" 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 . 1921 . to aug 3 . 1921.
that I last saw her alive on aug 3 . 1921.
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:

Coloma of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic tuberculosis of the lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Walter Ward M. D.

8/4 1921 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 6 1921
20 UNDERTAKER Joseph B Cook	ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be understood by any physician. See back of certificates. TION is very important. See instructions on back

D 55912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

D 55912

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1134 Argyle Ave ~~St.~~ 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Robins

(Residence in Baltimore: No. 1134 Argyle Ave ~~St.~~ 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH. 2 (Month) 2 (Day) 1867 (Year)

7-AGE.	If LESS than 1 day, ...hrs. or.....min.?
54 yrs. mos. ds.	

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Robinson

(Address) 1134 Argyle Ave

15-

Filed Aug 6-1921 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 4, 1921. (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 21st 1921, to Aug 4th 1921, that I saw h[er] alive on Aug 3d, 1921, and that death occurred, on the date stated above at 7.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma

Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 5 yrs. mos. ds.

(Signed) A. Fox Lee M. D.

Aug. 5, 1921. (Address) 924 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Easton Md

19-PLACE OF BURIAL OR REMOVAL. Easton Md.

DATE OF BURIAL. Aug 6, 1921.

20-UNDERTAKER Daniel Easton

ADDRESS 916 Penna ave

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 55913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55913

138

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (ST.) 22 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Morris.

(a) RESIDENCE NO. 634 Wayne St. (ST.) Balty. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND OF~~ ~~(or) WIFE OF~~: Daniel Morris (father) 634 Wayne St Balto Md.

6 DATE OF BIRTH (month, day, and year): March 7, ?

7 AGE: Years 15 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Daniel Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susie Turpin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Johns Hopkins Hospital. Records

15 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921. to Aug 1, 1921.
that I last saw her alive on Aug 1, 1921.
and that death occurred, on the date stated above, at 11.35 a.m.

The CAUSE OF DEATH* was as follows:
Puerperal eclampsia.

(duration) — yrs. mos 1 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) E. L. Stone M. D.
8/4. 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Ct.
DATE OF BURIAL: aug 1 1921

20 UNDERTAKER: L. L. Brown & Son
ADDRESS: 708 W. Monty

CAUSE OF DEATH in plain terms, so that no other cause can be substituted. See instruction on back of certificates. TION is very important.

G 6 — 1921

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55914

CERTIFICATE OF DEATH.

D 55914

REGISTERED NO. 107

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. No. 1532 Jackson St ST.: 24 WARD)

2-FULL NAME Paul Reynolds

(a) RESIDENCE. No. 1532 Jackson ST.. 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs 5 mos 10 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25 / 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Victor Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Kate Hirschfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Victor Reynolds 1532 Jackson St.

15 Filed Robert P. Harrison, Registrar

6-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4/21

17 I HEREBY CERTIFY, That I attended deceased from 7/29/21, 19 . to 8/4/21, 19 . that I last saw him alive on 8/4/21, 19 . and that death occurred, on the date stated above, at 5:15 P m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acidosis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James Brown, M. D.

(Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: Aug 6 192[illegible]

20 UNDERTAKER: Mrs. E. Evans & Sons — ADDRESS: 1428 Eutaw St

CAUSE OF DEATH in plain terms. No abbreviations or symbols. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55915

HEALTH DEPARTMENT—CITY OF BALTIMORE

40-9 D 55915

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Walker Avenue ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael F. Connor

(a) RESIDENCE. NO. 509 Walker Avenue ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. ds. How long in U. S., if of foreign birth? -- yrs. -- mos -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Fitzgerald

6 DATE OF BIRTH (month, day, and year) Sept. 4, 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Court Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Co, Court

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas, Balto. Co., Md.

PARENTS

10 NAME OF FATHER Patrick Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Finerty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) William Connor 509 Walker Ave. Govans

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

6-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1920, to Aug 4th, 1921, that I last saw h[illegible] alive on Aug 4th, 1921, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows: Carcinoma of Oesophagus

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis (duration) yrs. 5 mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct. 1920

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) [illegible] M. D

. 19 (Address) Texas Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Joseph's Cemetery, Texas — DATE OF BURIAL 8/8 1921

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS 805 N. Calvert

CAUSE OF DEATH to be plainly written, so that it may be read as a part of certificates. See instructions on back of certificates. This item is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill; (a) Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Information received from Dr. Bussey by phone. City case also.

(Griczin)

D 55916 HEALTH DEPARTMENT—CITY OF BALTIMORE 001 D 55916

CERTIFICATE OF DEATH. REGISTERED NO. C 175

1-PLACE OF DEATH University Hospital 21 WARD)
CITY OF BALTIMORE (NO. ~~708 S. Macon~~ ST.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Griczin

(Residence in Baltimore: No. 908 S Paca st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May (Month) 3 (Day), 1914 (Year)

7-AGE, 7 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

PARENTS.

9-BIRTHPLACE, (State or Country), Balt. Md

10-NAME OF FATHER, Anton Griczin

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Anna Moroneus

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anton Griczin

(Address) 908 S. Paca St.

15-

Filed....., 191.....

Robert P. Harrison, Burial Permit Clerk Registrar.

G 6—1921

CAUSE OF DEATH to be plain terms, so that no doubt may exist as to its nature. Name of disease alone is not sufficient. Indefinite terms, such as "Debility," "Old Age," "Cancer," "Consumption," "Paralysis," "Dropsy," "Fever," "Inflammation," "Hemorrhage," "Convulsions," "Tumor," "Ulcer," "Abscess," "Childbirth," "Accident," "Suicide," "Homicide," are not sufficient. Causes of death which may result from violence should be carefully stated, as they are always important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Gunshot shock, Fracture Lower Jaw, Lacerated Chest & Internal Injuries

..... (Duration) ..... yrs. a few hrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental Shock by gun

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

8-5, 1924 (Address) 117 N Sarabay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, Aug 6, 1921

20-UNDERTAKER James Dignan & Son

ADDRESS 1000 S Paca St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55917

CERTIFICATE OF DEATH. (Colgate Park)

D 55917

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 Prospect Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Elizabeth Norris

(Residence in Baltimore: No. 110 Prospect Ave St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, July (Month) 23 (Day), 1844 (Year)

7-AGE, 77 yrs. ..... mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Co.

PARENTS.

10-NAME OF FATHER, Isaac Norris

11-BIRTHPLACE OF FATHER (State or Country), Harford Co.

12-MAIDEN NAME OF MOTHER, Margaret Patten

13-BIRTHPLACE OF MOTHER (State or Country), Cecil Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Josephine White

(Address) 110 Prospect Ave

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

6-1921

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 8th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1919, to July 31st 1921, that I saw her alive on July 31st 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Complications of Chronic Interstitial Nephritis

Loss of Apetite Exhaustion

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) ..., ...yrs. 6 mos. ..... ds.

(Signed) Geo H Carnes M. D.

8/5/21 1921 (Address) 21 W 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto. Cemetery

DATE OF BURIAL, Aug. 8, 1921

20-UNDERTAKER A. E. Marshall 2539

ADDRESS Falls Rd.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Tinnie Butler)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55918 ✓ 79 D 55918

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2421 Hudson Pl ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tinnie Butler

(a) RESIDENCE. No. 2421 Hudson Pl ST., WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) June [illegible] 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Live in Balt 8 years Cunningham Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Armfield Gibson (Address) 2421 Hudson Place

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

G 6-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29th 1921, to Aug 4th 1921, that I last saw h[illegible] alive on Aug 4th 1921, and that death occurred, on the date stated above, at 9 25 p.m.

The CAUSE OF DEATH* was as follows:

Acute Articular Asthritis and Malignant Endocarditis

(duration) ? yrs. 1 mos. 25 ds.

CONTRIBUTORY (Secondary) Repeated Asthritis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? +

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physicians Diagnosis

(Signed) Ed L Stall, M. D.

, 19 (Address) 406 E 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 7 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1721 Wehland Ave

CAUSE OF DEATH ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55919

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 55919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1637 McElderry St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorthey Lee

(Residence in Baltimore: No. 1637 McElderry St.; ....yrs., 5 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	colored	Single

6-DATE OF BIRTH, ... May (Month) ..... 5 (Day) ....., 1921 (Year)

7-AGE, 0 yrs. 5 mos. ....ds. — If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). born in Balt- Balto city

PARENTS.

10-NAME OF FATHER, Joseph Lee

11-BIRTHPLACE OF FATHER (State or Country). N. C.

12-MAIDEN NAME OF MOTHER Lillian Johnson

13-BIRTHPLACE OF MOTHER (State or Country). Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Lee

(Address) 1637 McElderry St

15-

Robert P. Harrison,

Filed....., 191..... Registrar.

G 6-1921 Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug (Month) ..... 5 (Day) ....., 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1921, to Aug 5 1921, that I saw h[illegible] alive on Aug 4 1921, and that death occurred, on the date stated above, at 11 5 m. pm

The CAUSE OF DEATH* was as follows:

(a) Died - Colitis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Edward Fisher M. D.

8-6, 1921 (Address) 1612 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Aug 7..., 1921
20-UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Av

Spec.—8-24-14—M. & T.—2000 Bks.

D 55920 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55920

CERTIFICATE OF DEATH. 152

1-PLACE OF DEATH Women's Hospital REGISTERED No. C

CITY OF BALTIMORE: (No. Lafayette & John ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Abel

(Residence in Baltimore: No. Women's Hospital St.; 0 yrs., 0 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Infant Single

6-DATE OF BIRTH, August (Month) 4 (Day), 1921 (Year)

7-AGE,	If LESS than 1 day,
0 yrs. 0 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): Infant 160

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph H. Abel

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ernestine Wahler

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. H. Abel

(Address) Bridge Market & Ellicott Sts

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

G 6-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 5th (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 4 (birth) 1921, to Aug 5 1921, that I saw him alive on Aug 5 1921, and that death occurred, on the date stated above, at 4:45 P.m.

The CAUSE OF DEATH* was as follows:

Atelectasis of Lungs

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) congenital weakness

(Duration) — yrs. — mos. 2 ds.

(Signed) D. M. Stiefel M.D.

Aug. 5, 1921 (Address) Hospital for Women, Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 2 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Place of death

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Aug 6, 1921
20-UNDERTAKER Wm J Lickner & Son	ADDRESS W Balto Pa.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 55921 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55921

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... St.: 10 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Stewart

(a) RESIDENCE. No. 730 N. Gay St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 6-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — 000
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Edward Stewart
11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.
12 MAIDEN NAME OF MOTHER Anna S Cohen
13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country) Md.

14 Informant Edward Stewart (Address) 730 N Gay

15 Filed Aug 6-1921. Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to 8/5, 1921, that I last saw him alive on 8/6, 1921, and that death occurred, on the date stated above, at 8 55 A m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
TE

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition
(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I Zinberg, M. D.

8/5, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 8 1921
20 UNDERTAKER	ADDRESS
Frank Brachot	116 Ashland

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55922

CERTIFICATE OF DEATH.

45 D 55922

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 North Carey St. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George G. Muth

(a) RESIDENCE. NO. 309 North Carey St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leona E. Becker

6 DATE OF BIRTH (month, day, and year) Oct. 30, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) 975

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John P. Muth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary M. Foudriat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Leona E. Muth

(Address) 309 N. Carey St.

15 Filed Aug 6-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 18 1920, to Aug 4th 1921, that I last saw him alive on Aug 4th 1921, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Retroperitoneal Adenos-Carcinoma Situated between Spine & Left Kidney, and Running down Spine to pelvis.

Abouts (duration) — yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary) Left Pyelo-Nephritis (duration) — yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes. Date of Feb 15/21

Was there an autopsy? No

What test confirmed diagnosis? microscopic section

(Signed) Charles Lieb M. D.

Aug 6 1921 (Address) 1111 W. Lanvale St. Charles Lieb,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/8/21 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son,	805 N. Calvert

CAUSE OF DEATH in plain terms. Abbreviations must not be used. Any information lacking on face of certificate should be supplied if possible. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55923

CERTIFICATE OF DEATH.

152 D 55923

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2713 Greenmount Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ellwood

(a) RESIDENCE. NO. 2713 Greenmount Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~.....~~ none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Fred Ellwood.

11 BIRTHPLACE OF FATHER (city or town) Unk
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Wray

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Margaret Ellwood
(Address) 2731 N Calvert St

15 Filed AUG 6-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1921

17 I HEREBY CERTIFY, That I attended deceased from July 31 1921, to August 1921,
that I last saw her alive on August 1921,
and that death occurred, on the date stated above, at 11:15 P. m.
The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Premature infant.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ~~.....~~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Dr Ellwood, M. D.

, 19 (Address) 2631 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Texas Md.

DATE OF BURIAL August 1921

20 UNDERTAKER Leo G. Leach

ADDRESS Northeast Baltimore

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

14978 . D 55924

HEALTH DEPARTMENT—CITY OF BALTIMORE D 55924

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 18 WARD)

2-FULL NAME Dorothy Romeo

(a) RESIDENCE NO. Florence Crittenden Home ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24. 20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	1	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Minnie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Johns Hopkins Hospital Records.

15 6-1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1920, to Aug 4, 1921, that I last saw h Er alive on Aug 4, 1921, and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) 1 yrs. 1 mos 11 ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery)

(duration) — yrs. — mos. 11 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. Davies, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetary — DATE OF BURIAL Aug. 6 1921

20 UNDERTAKER Mr. & Mrs. H. S. Fink. — ADDRESS 1835 N Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. ATTENTION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

140557 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55925

D 55925

CERTIFICATE OF DEATH. 30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Bailey.

(a) RESIDENCE NO. 414 W. Hamburg St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 1 - 1916.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	5	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Moses Anthony.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adline Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital (Address) Nurse.

15 Filed AUG 7 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1921, to Aug 5, 1921, that I last saw her alive on Aug 5, 1921, and that death occurred, on the date stated above, at 6:30 p m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Miliary tuberculosis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray & lumbar puncture

(Signed) Wm Garrison, M. D.

(Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL Aug 8 1921

20 UNDERTAKER R. L. Parham

ADDRESS 649 W Lexington

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

55926

HEALTH DEPARTMENT—CITY OF BALTIMORE

H V D 55926

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 Pressbury ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Burk.

(Residence in Baltimore: No. 2100 Pressbury St.; 25 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Aug (Month) 5 (Day), 1878 (Year)

7-AGE, 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Nathan Samuel

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mary Sano

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Samuel

(Address) 2100 Pressbury St.

15- Filed AUG 7-1921, 191.... ROBERT J. KRAUTER Registrar

CAUSE OF DEATH must be stated for every death. See instructions on back of certificate. Typewriting or printing is important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1921, to Aug 5 1921, that I saw h[illegible] alive on Aug 5 1921 and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Carcinoma of Uterus & Appendix of Ovaries

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Debility

(Duration) yrs. 7 mos. ds.

(Signed) Edward A. Mayer M. D.

Aug 6, 1921 (Address) 1332 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltic Hebrew Cem	Aug 7. 1921
20-UNDERTAKER J. Ahrens Co.	ADDRESS 1611 Madison

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55927

CERTIFICATE OF DEATH.

120 D 55927

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 N.Wolfe ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Galloway

(a) RESIDENCE NO. 1707 N.Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or WIFE of)

6 DATE OF BIRTH (month, day, and year) Dec 24.1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Colgate, Maryland

PARENTS

10 NAME OF FATHER: Vincent Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Colgate, Maryland

12 MAIDEN NAME OF MOTHER: Rachel Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs William G.Lynch, Colgate Md

15 FILED AUG 7 - 1921 [illegible] Registrar

CAUSE OF DEATH IS PLAINLY TO BE STATED. See instructions on back of certificates. THION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug.5.1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1921, to Aug 5, 1921, that I last saw her alive on Aug 4, 1921, and that death occurred, on the date stated above, at 5:20 A m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma — Complication

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstit Nephritis & Arteriosclerosis (duration) Probably 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam. Only

(Signed) Thos R Geraghty, M. D.

Aug 6 1921 (Address) 203 E Preston St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	8-7-21 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55928

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 55928

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1604 E Chase ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest J C Schroeder.

(a) RESIDENCE. NO. 1604 E Chase. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Oct 23 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 131

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fred Schroeder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Mrs Schroeder X (Address) 1604 E Chase St

15 Filed AUG 7 - 1921 ROBERT J. CRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15 . 1921 . to August 4 . 1921 . that I last saw h.m alive on August 3 . 1921 . and that death occurred, on the date stated above, at 1 P.m.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder
(Haemorrhage)

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Post Mortem

(Signed) W A Connell, M. D.

. 19 (Address) 9 West Royal Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 8 1921

20 UNDERTAKER Henry Lutz ADDRESS 1807 N. Bond St

CAUSE OF DEATH must be plainly written, and the certificate filled out in every particular. See instructions on back of certificate. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

Koenig

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 55929

55929

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Koenig

(a) RESIDENCE. NO. 2316 Erdman Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) May 15 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sander in rubber off

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Koenig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs Koenig (Address) 2316 Erdmand ave

15 Filed AUG 7 - 1921 ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4th. 1921

17 I HEREBY CERTIFY, That I attended deceased from the July 21st. 1921, to Aug. 4th. 1921, that I last saw him alive on Aug. 4th. 1921, and that death occurred, on the date stated above, at 11.35 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hypertrophic Cirrhosis

(duration) ! yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Zinberg, M. D.

8/4, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
London Park	Aug 8 1921

20 UNDERTAKER	ADDRESS
Henry Lutz	1007 N. Bond

CAUSE OF DEATH must be given in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55930

CERTIFICATE OF DEATH.

892 55930

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5302 Harford ave ST.: 27 WARD)

2-FULL NAME Elizabeth Mainley

(a) RESIDENCE. NO. 5302 Harford Ave ST.: ..... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced ~~DAUGHTER~~ of (or) WIFE of: Danl. Mainley

6 DATE OF BIRTH (month, day, and year): May 4, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Aires

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Ellen Sapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

11 Informant: Mrs Robt. Perkins (Address) 5302 Harford ave

15 Filed AUG 7 - 1921 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1921, to Aug. 4th, 1921, that I last saw her alive on Aug. 4th, 1921, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Atheroma

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Exam. of chest & vessels,

(Signed) L. O. Schwatka M. D.

, 19 (Address) 822 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug 8 1921

20 UNDERTAKER: Henry Lutz — ADDRESS: 1007 N. Bond st

CAUSE OF DEATH to plain terms. Do not use abbreviations or technical terms. Do not state mode of dying, but the disease or injury which caused death. If deaths from violence, state whether accidental, suicidal or homicidal. If from accident, state whether it occurred in mine, factory, railroad, etc. If a woman, whether single, married, widowed or divorced. If death occurred in a hospital or institution, the name of the institution should be given instead of the street and number. If the deceased had been ill, the physician should be requested to fill out the certificate. If he refuses, the undertaker should notify the Registrar at once. If the cause of death is unknown, the Registrar should be notified. The certificate must be filled out in every case before a permit for burial will be issued. The Registrar's number must be given on the coffin. TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 55931

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045 55931

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (NO. ..... ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Smitkin

(Residence in Baltimore: No. 2033 E Fairmont Ave St.; ..... yrs. 6 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Feb ..... (Month) ..... (Day), 1921 (Year)

7-AGE, ... yrs. 6 mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph Smitkin

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Bessie Abelman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Baltimore

15- Filed AUG 7 1921, 191 ..... ROBERT B KRAUTER Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8/6 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12 1921, to 8/6 1921, that I saw her alive on 8/6 1921, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows: DFW

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

8/6/21, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State 5 yrs. 6 mos. ..... ds.

Where was disease contracted, if not at place of death? at Home

Farmer or usual residence 2033 E. Fairmont Ave

19-PLACE OF BURIAL OR REMOVAL Hebrew Mod. Rod — DATE OF BURIAL, 8/7, 1921

20-UNDERTAKER Joel Louis — ADDRESS 1411 E Baltimore

important. See instructions on back of certificate.

Acute entero colitis

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec. - 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55932

CERTIFICATE OF DEATH.

108 D 55932

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Schaffer

(a) RESIDENCE. NO. 1438 E. Baltst ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Schaffer

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1411 E Baltst

15 Filed AUG 7 - 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1921, to August 6, 1921, that I last saw her alive on August 6, 1921 and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Acute Myocardial failure

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Hyperchlorhydria, Peritonitis, Intestinal Obstruction (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Ellicott City Md.

Did an operation precede death? yes Date of Aug. 1/21

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Louis Jacks, M. D.

Aug 6 1921 (Address) The Hebrew Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 8/7/21 19

20 UNDERTAKER Jack Levis ADDRESS 1411 E Baltst

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or initials. Do not write on back of certificates. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55933

CERTIFICATE OF DEATH.

172 D 55933

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Schlong Sterman

(a) RESIDENCE. NO. 1028 Granby St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible] Sterman

6 DATE OF BIRTH (month, day, and year) Feb 10-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis Jr. Hebrew Hosp (Address) Balto & Howard

15 Filed AUG 7 - 1921 ROBERT A. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-25-1921 to 8-6-1921, that I last saw her alive on 8-6-1921, and that death occurred, on the date stated above, at 5:45 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, (Acute)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture neck of humerus (left) (duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? 1028 Granby St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical X-ray.

(Signed) Louis Jack, M. D.

Aug. 6, 1921 (Address) Hebrew Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] BURIAL

Hebrew Benevolent Assn

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto St

CAUSE OF DEATH to be filled in plainly in ink. Be sure that every item is correctly stated. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—B. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55934

CERTIFICATE OF DEATH.

120 D 55934

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1 N. Wheeler Ave. St.; W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Ran

(a) RESIDENCE. No. 1 N. Wheeler Ave Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leyza Ran

6 DATE OF BIRTH (month, day, and year) June 20 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

003

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Tena Ran

(Address) 1 N Wheeler Ave

15 Filed AUG 7 - 1921 19 ROBERT I. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1920, to Aug 5, 1921, that I last saw him alive on Aug 5, 1921, and that death occurred, on the date stated above, at 7.53 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis 9

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia and Senile Arterial Sclerosis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? ? Date of ?

Was there an autopsy?

What test confirmed diagnosis? ?

(Signed) Dr Theo. W. Koldenow M. D.

(Address) 34 So Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Aug. 8 1921
20 UNDERTAKER C. W. Dill.	ADDRESS 3109 Fredk Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55935

CERTIFICATE OF DEATH.

150

D 55935

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3915 Mt. Pleasant Ave. St.; No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Freda Ahms

(Residence in Baltimore: No. 3915 Mt Pleasant Ave. St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, August 6 (Month) (Day), 1921 (Year)

7-AGE, ... yrs. ... mos. ... ds. If LESS than 1 day, 4 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), 3915 Mt Pleasant Ave

PARENTS.

10-NAME OF FATHER, Harry Ahms

11-BIRTHPLACE OF FATHER (State or Country), Cuba

12-MAIDEN NAME OF MOTHER Catherine Elizabeth Shannon

13-BIRTHPLACE OF MOTHER (State or Country), Cuba

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Ahms

(Address) 3915 Mt Pleasant Ave

15- AUG 7 - 1921 ROBERT J. KRAUTER

Filed ....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 6 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 3 1921, to Aug 6 1921, that I saw her alive on Aug 6 191..., and that death occurred, on the date stated above, at 9.20 A m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of Heart

(Supplemental Asphyxia)

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....

(Duration) ...yrs. ...mos. ...ds.

(Signed) Alfred A. Bondurant M. D.

Aug 6....., 1921 (Address) 3915 Mt Pleasant Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Balto Cem — DATE OF BURIAL, Aug 8 1921

20-UNDERTAKER Philip Herring — ADDRESS 2016 Orleans

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55936

CERTIFICATE OF DEATH.

64 D 55936

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 N. Charles ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William D. Gosnell

(Residence in Baltimore: No. 2509 N. Charles St.; 59 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Feb. 13, 1862 (Month) (Day) (Year)

7-AGE, 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer): O.K.

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James L. B. Gosnell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Adalade Gosnell

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace T. Gosnell

(Address) 2509 N. Charles St.

15- AUG 7-1921 BOWERY & EXCHANGE

Filed ....., 191.... Burial Permit ..... Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 4 1921, to August 5 1921, that I saw him alive on August 5 1921, and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Cardio nephropathy

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. 1 mos. ds.

(Signed) Geo. W. Stitt M.D.

August 7, 1921 (Address) 2435 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Aug. 8, 1921

20-UNDERTAKER Chas. E. Franck ADDRESS N. Madison Ave.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55937

D 55937

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~Ella~~ 122 W. Lafayette ave. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella M. Hachtel

(a) RESIDENCE. NO 122 W. Lafayette ave. ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of: Charles E. Hachtel

6 DATE OF BIRTH (month, day, and year): Feb. 27. 1860

7 AGE — Years: 61 — Months: 4 — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md.

PARENTS

10 NAME OF FATHER: Thomas J. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Matilda Chapell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant (Address): Dr. Frank W. Hoch 1327 W. Lafayette Ave

15 Filed AUG 7 - 1921 [illegible] Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30 1921, to Aug. 5 1921, that I last saw h er alive on Aug. 4 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uraemic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. Schmit, M. D.

Aug. 7 1921 (Address) 701 N. Fremont ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Herring Run

DATE OF BURIAL: 8-8 1921

20 UNDERTAKER: Edward Watkins Sons Co

ADDRESS: Woodlawn Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 55938

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2229 St Paul St ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Francis McCabe

(a) RESIDENCE. No. 2229 Saint Paul ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~the WIFE of~~ Kate Snowden McCabe

6 DATE OF BIRTH (month, day, and year) May 10th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	2	27	

8 OCCUPATION OF DECEASED 030

(a) Trade, profession or particular kind of work Civil Engineer & Construction

(b) General nature of industry, business, or establishment in which employed (or employer) Jas. F. McCabe Construction Co.

(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) Havre de Grace Maryland

PARENTS

10 NAME OF FATHER Lawrence McCabe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose McFaley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Richard J. McCabe (Address) 2229 St Paul St

15 AUG 7 - 1921 ROBERT E. LAZENBY Burial Permit Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to Aug 6th, 1921, that I last saw h live on Aug 5th, 1921, and that death occurred, on the date stated above, at 6.45a m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pyuria - bacteruria - etc

(Signed) Wm J Watson, M. D.

Aug 6, 1921 (Address) 2126 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Cem Govans	8-8 1921

20 UNDERTAKER Henry W Jenkins & Sons Co ADDRESS 110 Liddel & Preston

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55939

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55939

CERTIFICATE OF DEATH.

1919

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 Park Ave. Raspeburg St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L. Oelschlager

(a) RESIDENCE. NO. 34 Park Ave. Raspeburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Oelschlager

6 DATE OF BIRTH (month, day, and year) Feb. 19 1891

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	30	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookbinder 164

(b) General nature of industry, business, or establishment in which employed (or employer) Albrecht Company

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. W. Oelschlager

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Stein

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs. Anna Oelschlager
(Address) 1807 E. Biddle St.

15 Filed Aug. 7 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1921, to Aug. 5, 1921, that I last saw him alive on Aug. 4, 1921, and that death occurred, on the date stated above, at 4.55 A. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation and Stenosis ?

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

8/5, 1921 (Address) Raspeburg, Balt, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Aug 8 1921

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55940

CERTIFICATE OF DEATH.

75-001 D 55940

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1 Ann E Gough St. ✓ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Loretta Colbert

(Residence in Baltimore: No. 309 South Ann St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Jan 4, 1919 (Month) (Day) (Year)

7-AGE. 6 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Washington D.C.

PARENTS.

10-NAME OF FATHER: William A. Colbert

11-BIRTHPLACE OF FATHER (State or Country): Washington D.C.

12-MAIDEN NAME OF MOTHER: Fannie Koerner

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William A. Colbert
(Address) 309 South Ann St.

15- Filed AUG 7-1921, 191... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidentally crushed to death by an auto motor truck

Temporary permit (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) may be assumed (Duration) yrs. mos. ds.

(Signed) Dr. S. Bradley M. D.
(Coroner)
Aug 7, 1921 (Address) 1800 N. Eden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Cross Harford Rd. — DATE OF BURIAL: Aug 8, 1921

20-UNDERTAKER: William Cook — ADDRESS: 502 E. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55941

CERTIFICATE OF DEATH.

175-001

D 55941

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 432 S Eden St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Saulino

(Residence in Baltimore: No. 432 S Eden St.; 51 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Smal Boy

6-DATE OF BIRTH, May (Month) 18 (Day), 1870 (Year)

7-AGE, 7 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Smal Boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Harry Saulino

11-BIRTHPLACE OF FATHER (State or Country), Ittly

12-MAIDEN NAME OF MOTHER Rose Zuchi

13-BIRTHPLACE OF MOTHER (State or Country), Ittly

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Saulino

(Address) 432 S. Eden

15- AUG 7-1921 [redacted] REUTER

Filed, 191.. [redacted] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Accidental (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Crushed by Car

Contusion of Chest

Duration 2 hr Instantaneous

Automobile Accident

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [redacted] M. D. (Coroner)

8/7/21, 191.. (Address) 1004 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL
St Vincents	Aug 8, 1921
20-UNDERTAKER	ADDRESS
Wendell Ryffel & Son	37 S Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

St Vincents Infant Asylum. 1401 - Division S

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55942

D 55942

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 - Division ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Legat

(a) RESIDENCE. NO. 1401 - Division ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 6" 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Legat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Anna Hausch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Sister Dora

(Address) St Vincents Inf Asylum

15 Filed AUG 7 - 1921 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25" , 1921 , to Aug 5" , 1921 ,

that I last saw h[illegible] alive on Aug 5" , 1921 ,

and that death occurred, on the date stated above, at 4-30 P m.

The CAUSE OF DEATH* was as follows:

Dysentery. (Entero-Colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Chas O'Donovan. per Ch. Clanton M.D.

Aug 6 1921 (Address) 5" E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glenmont Va	Aug 7th 1921

20 UNDERTAKER P. F. Fahey & Sons

ADDRESS Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or ditto marks. Be particular and definite. Do not return this form to the undertaker. He is not entitled to a copy of certificates. TION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55943

CERTIFICATE OF DEATH.

420 55943

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Aisquith ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Lee

(a) RESIDENCE. NO. 1725 Aisquith ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
f	w	widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Lee

6 DATE OF BIRTH (month, day, and year) Dec 1, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N.W. 001

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry C. Schultz (Address) 113 C Collins ave

15 AUG 7 - 1921 ROBERT J. KRAUTER Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5/21 19

17 I HEREBY CERTIFY, That I attended deceased from 6/20/21, 19 . to 8/5/21, 19 ,

that I last saw h.. alive on 8/4/21, 19 ,

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Cystic adenocarcinoma ovaries

(duration) Histy yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Apr. 1921

Was there an autopsy? No.

What test confirmed diagnosis? Path ex

(Signed) Bernard J Finy, M. D.

8/5/ 1921 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartze Cemetery

DATE OF BURIAL Aug 8 1921

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 Eager st

CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55944

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Howard A Kelly Hospital Inc

CITY OF BALTIMORE: NO. 1418 Eutaw Place ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Eliza Moss.

(a) RESIDENCE. NO. 479 Cobb St. Athens Ga. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Apr. 13-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Rufus L. Moss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Elizabeth Lucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Dr. Wm. L. Moss (Address) Athens Ga

15 Filed AUG 8 - 1921 19... Registrar

CAUSE OF DEATH in plain terms, so that it may be classified. Do not use abbreviations or terms of doubtful meaning. Do not report symptoms, but the disease causing death. If the death was due to external violence, state the nature of injury, and whether accidental, suicidal, or homicidal. Do not report mode of dying, as "shock," "hemorrhage," or "exhaustion" without the cause. When there is more than one cause of death, state the one which started the fatal train of events last. Operations should be reported only when performed for some other disease than that which caused death. Write plainly with pen and ink. Use no lead pencil. Fill all blanks with definite statement. If unknown, say so. Do not leave blanks. Consult the back of certificates. ATTENTION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7. 1921

17 I HEREBY CERTIFY, That I attended deceased from July 22 1921, to Aug 7 1921, that I last saw her alive on Aug 7 1921, and that death occurred, on the date stated above, at 9.50 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 7+ mos. ds.

CONTRIBUTORY (Secondary) Visceral metastases

(duration) yrs. 7+ mos. ds.

18 Where was disease contracted if not at place of death? U. S. A.

Did an operation precede death? yes Date of Jul 2. 1921

Was there an autopsy? no (Blood).

What test confirmed diagnosis? Pathological section

(Signed) Theleane Heick Jr., M. D.

Aug 7. 1921 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Athens Georgia	Aug 8 1921

20 UNDERTAKER John O. Mitchell ADDRESS 231 W. Fayette

Spmc.—6-9-19—H. P. Co.—1000 Bks.

D 55945

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55945

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Maryland General Hospital. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Gaston

(a) RESIDENCE. NO. Laurel Md. ST., ... WARD. Laurel Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Gaston.

6 DATE OF BIRTH (month, day, and year) May 24, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Garage. 088

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer O W. Phair Syracuse N.Y.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER C.A. Gaston

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER C.B. Cummo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.

14 Informant (Address) Frank Gaston. Mrs Frank Gaston Laurel Md.

15 Filed AUG 8 - 1921 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1921, to August 7, 1921, that I last saw h in alive on August 7, 1921, and that death occurred, on the date stated above, at 8.00 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 7 mos. ds. Cardiac Decompensation

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Laurel Md.

Did an operation precede death? Yes Date of 7/15/21 & 8/1/21

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic Section Biopsy

(Signed) Fred J Bamfield M. D.

8/5 1921 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md	8/10/ 1921
20 UNDERTAKER John J Fahey Son	ADDRESS 1318 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact technical or hospital terms may be used in addition, but not instead of certificates. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Kulz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55946

CERTIFICATE OF DEATH.

6-04 D 55946

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Felct ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Louis Kutz

(a) RESIDENCE. NO. 2500 Felct ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Kutz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Swarczynski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Henry Kutz 2500 Felct

15 Filed AUG 8 - 1921 ROBERT I. [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 7 1921

17 I HEREBY CERTIFY, That I attended deceased from aug 6 1921, to aug 7 1921

that I last saw him alive on aug 6 1921

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) [illegible], M. D.

(Address) 2000 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	aug 8 1921

20 UNDERTAKER John M. Weber ADDRESS 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Lillian Harms) D 55947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55947

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 E Eager ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lilian Garnt

(a) RESIDENCE. NO. 929 E Eager ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Childs

6 DATE OF BIRTH (month, day, and year) July 25 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm H Harms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna Helmke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr. Wm H. Harms (Address) 929 E Eager St

15 Filed AUG 8-1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1921

17

I HEREBY CERTIFY, That I attended deceased from 8-3-21, 19..., to 8-7-21, 19...

that I last saw h.. alive on 8-7-21, 19...

and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Ulceration Stomach

Gen. Septicemia

Forearm (duration) yrs. mos. 4½ ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. Symons M.D.

8-7-21 19 (Address) 25 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Aug 8 1921

20 UNDERTAKER Elmer W Conklin ADDRESS 924 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Margaret L. Harris.
6 Yeark.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr Seamore
2520 -
Monument - St
Full term baby. Att 4 days
after birth started with ulcers
for mouth. Gastro intestinal
trouble.

Spec.—8-24-14—M. & T.—2000 Bks.

Krebs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55948

D 55948

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Hanover St ST.) 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilhelmina Krebs

(Residence in Baltimore: No. 1211 Hanover St.; ....yrs., ...mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH. Dec. (Month) 8 (Day), 1873 (Year)

7-AGE.	If LESS than 1 day.
47 yrs. 7 mos. 28 da.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 131

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John A Krebs

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Wilhelmina Fleischer

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma M. Krebs

(Address) 1211 Hanover St

15- AUG 8-1921 Filed....., 191.... ROBERT J. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 6th (Month) (Day), 1921 (Year).

17-I HEREBY CERTIFY, That I attended deceased from July 15 1921, to Aug 6th 1921, that I saw h.. alive on Aug 6 1921, and that death occurred, on the date stated above, at 11 1/2 m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's

(Duration) yrs. 3 mos. — da.

CONTRIBUTORY (Secondary) Hypertension

(Duration) yrs. 1 mos. 2 da.

(Signed) A Pfeiffenstein M. D.

8/6, 1921 (Address) 1310 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Aug 9th, 1921
20-UNDERTAKER B Lehman & Son	ADDRESS 1037 Hanover St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. important.

Spec.—8-24-14—M. & T.—2000 Bks.

Fannie M Grace

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55949 D 55949

CERTIFICATE OF DEATH.

REGISTERED NO. C 25 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2215 Columbia ave extended ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie May Grace

(Residence in Baltimore: No. 2215 Columbia Ave St. Life yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb 2 (Month) 4 (Day) 1921 (Year)

7-AGE, ...yrs. 6 mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER. John F Grace

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Maggie V. Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F Grace

(Address) Mt Winans

AUG 8-1921 Filed....., 191.... ROBERT A KRAUTER Registrar

Burial Form Given

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8-6 1921, to 8-6 - 191, that I saw her alive on 8-6-21 191, and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

Immersion

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency + exhaustion

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J E Grace M. D.

8-7-, 191.. (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Western — DATE OF BURIAL, Aug 9, 191...

20-UNDERTAKER John J Fiddes — ADDRESS 1100 N Fremont

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55950

104 D 55950

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1249 William ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Joseph Dolan

(a) RESIDENCE. NO. 1249 William ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John J. Dolan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Mary Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John J Dolan Father
(Address)

15 FILED AUG 8 - 1921 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 . 1921 . to Aug 7 . 1921 .

that I last saw h. alive on Aug 6 . 1921 .

and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. 1 hr. ds.

CONTRIBUTORY (Secondary) Acute Gastro Enteritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C W Mehrle M. D.

Aug 7. 1921 (Address) 1249 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a&c	8-8 1921
20 UNDERTAKER E & B Hasle	ADDRESS 115 E Lexington St

MAKE SURE THAT CAUSE OF DEATH IS properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55951

CERTIFICATE OF DEATH.

92-010

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 S Dallas ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Ringer

(Residence in Baltimore: No. 13 S Dallas St. St. 41 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-WHETHER SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH. June 6, 1876
(Month) (Day) (Year)

7-AGE. 45 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country) S. Carolina

PARENTS.

10-NAME OF FATHER. not known

11-BIRTHPLACE OF FATHER (State or Country). S. Carolina

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country). S. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Thomas

(Address) 13 S Dallas St.

15- AUG 8-1921 Filed ..... 191... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1921, to Aug 6 1921, that I saw h in alive on Aug 6 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) La Grippe

(Duration) yrs. mos. 3 da.

(Signed) Richard L Coolidge M. D.

Aug. 6, 1921 (Address) 1514 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence South Carolina

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel	Aug 9, 1921
20-UNDERTAKER John W Henderson & Monument	ADDRESS 1502

CAUSE OF DEATH in plain terms, so that it may be properly classified. Care taken to secure important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55952

CERTIFICATE OF DEATH.

28 D 55952

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 S. Potomac ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion E. Letsch

(a) RESIDENCE. No 1010 S. Potomac ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) Aug. 26. 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Wm. C. Letsch.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Minnie Schaffhein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Augusta Deuerling

(Address) 1010 S Potomac St

15 Filed AUG 8 - 1921 ROBERT I. [illegible] Registrar

Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19 . 1921 . to Aug 6 . 1921 . that I last saw h ed alive on Aug 6 1921, and that death occurred, on the date stated above, at 12 15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? bacteriological

(Signed) Edward Novak, M. D.

, 19 (Address) 1911 W. Patterson Park Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery

DATE OF BURIAL: Aug 9 1921

20 UNDERTAKER: Zickler + Zickler

ADDRESS: 1739 E. Eager

mation should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55953

CERTIFICATE OF DEATH.

120 D 55953

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Bentalou ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl A. Miller

(a) RESIDENCE. No. 1708 Bentalou ST., 15 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eliza a miller

6 DATE OF BIRTH (month, day, and year) 10 Jan 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing 673

(b) General nature of industry, business, or establishment in which employed (or employer) Formerly a Locomotive Engineer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna (Hanover)

PARENTS

10 NAME OF FATHER Joseph Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna (Hanover)

12 MAIDEN NAME OF MOTHER Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna (Hanover)

14 Informant Nathan Lewis
(Address) 1708 Bentalou St

15 Filed AUG 8 - 1921 19 [redacted] Registrar
Burial permit Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 5th, 1921, to August 5th, 1921, that I last saw h im alive on August 5th, 1921, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 3 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Ataxic Paraplegia

(duration) 5 yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Wm J Swain M. D.

(Address) 1701 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hanover P. A.	Aug 7th 19 21

20 UNDERTAKER Josiah Sefer ADDRESS 1600 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55954

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55954

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 1652 N. Gilmor St.: 15 WARD)

2-FULL NAME Dona Carter

(a) RESIDENCE. No. 1652 N. Gilmor St., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 2 Yr. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert D. Carter

6 DATE OF BIRTH (month, day, and year) Oct 25 - 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Peter A. Burkhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Leuthauser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Robert D. Carter 1652 N. Gilmor St

15 Filed AUG 8 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from December 5th 1919 to August 7th 1921, that I last saw her alive on August 7th 1921, and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 1 yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? — No

What test confirmed diagnosis? Formation of Stomach Contents

(Signed) Wm J Sellman M. D.

8/8. 1921 (Address) 1701 N Eutaw Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Aug 10. 1921

20 UNDERTAKER ADDRESS

Josiah Seyfer 1600 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

147403
D 55955

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 55955

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey Bennett.

(a) RESIDENCE NO. 2818 Huntington Ave ST., Balto WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6.	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Bennett.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Unknown.
(State or country)

14 Informant Johns Hopkins Hospital
(Address) Records.

15 Filed AUG 8 - 1921, 19 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7. 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 8. 1921, to Aug 7. 1921.

that I last saw her alive on Aug 7 1921.

and that death occurred, on the date stated above, at 10:15 a m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Substernal Lymphatic

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. Davies, M. D.

8. 7. 21 (Address) J H H

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Helena

DATE OF BURIAL Aug 8 1921

20 UNDERTAKER David Earlom

ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 55956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55956

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 761 W. Mulberry ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Elizabeth Woodson

(a) RESIDENCE. NO. 761 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/21/19

7 AGE — Years: 1 — Months: 11 — Days: 17 — If less than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James A Woodson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Loretta Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant James A Woodson (Address) 761 W. Mulberry St

15 Filed AUG 8 1921, 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7/1921

17 I HEREBY CERTIFY, That I attended deceased from 8/2/ 1921, to 8/7/ 1921, that I last saw h[illegible] alive on 8/7/ 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation preeede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Norris M. D.

8/11/21 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 8 1921
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55957

CERTIFICATE OF DEATH.

136 D 55957

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.; 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Wilson

(a) RESIDENCE. NO. 707 Josephine ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sam Wilson

6 DATE OF BIRTH (month, day, and year) — 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mollie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Viola Wilson

(Address) Deceased

15 Filed ....., 19 .....

AUG 8—1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6 1921

17 I HEREBY CERTIFY, That I attended deceased from August 6, 1921, to August 6, 1921, that I last saw her alive on August 6, 1921, and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

during Quinsy Tonsilitis FOR

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Frequency Contracted pelvis abdominal Caesarean section, (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 6 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Reese M D, M. D.

8 6, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 9 21
20 UNDERTAKER	ADDRESS 916
Daniel Easter	Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 55958

CERTIFICATE OF DEATH.

120 D 55958

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No 1649 Poplar Grove St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Tschantre

(a) RESIDENCE. NO. 1649 Poplar Grove ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lina Tschantre

6 DATE OF BIRTH (month, day, and year) Sept. 21, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Jewelry 038

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Switzerland

PARENTS

10 NAME OF FATHER: Abraham Tschantre

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Rosina Aeschbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant (Address): Leon E. Tschantre Cambridge Md.

15 Filed AUG 8 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. , 1920, to Aug 6 , 1921.

that I last saw him alive on Aug 6 , 1921,

and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema. (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. H. Cullen M. D.

8/8/21 (Address) 2757 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Aug 8 1921

20 UNDERTAKER: John O. Mitchell ADDRESS 1901 W. Fayette

mation should be carefully supplied. AGE should be stated Exactly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55959

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 55959

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3442 Auchentoroly Terrace WARD) 23

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Daniel Baker.

(Residence in Baltimore: No. 3442 Auchentoroly Terrace St.: 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: March (Month) 23 (Day), 1858 (Year)

7-AGE: 63 yrs. 4 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Timer
(b) General nature of industry, business, or establishment in which employed (or employer): Stone Co.

9-BIRTHPLACE, (State or Country): Frederick Co Md

PARENTS.

10-NAME OF FATHER: Daniel Baker

11-BIRTHPLACE OF FATHER (State or Country): Fred Co Md

12-MAIDEN NAME OF MOTHER: Ann C. Frieger

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Baker Jr.

(Address) 3442 Auchentoroly Ter

15- Filed AUG 8-1921 19[illegible] Registrar [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1 1921, to August 8 1921, that I saw h im alive on August 8 1921, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Spine

(Duration) 1 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (Duration) yrs. mos. 1 ds.

(Signed) John T. King Jr. M. D.

Aug. 8, 1921 (Address) 11 E. Chase St. Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park DATE OF BURIAL, Aug. 10, 1921

20-UNDERTAKER: John Littlefield ADDRESS 1201 N. Gay St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55960

CERTIFICATE OF DEATH.

1924 D 55960

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 Druid Hill av ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Thomas (Mary C Thomas.)

(a) RESIDENCE. No. 938 Druid Hill ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Blk	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Thomas

6 DATE OF BIRTH (month, day, and year) unknown 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
70	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St Mary Co Md

PARENTS

10 NAME OF FATHER John Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) William H. Thomas 938 Druid Hill ave.

15 AUG 8 - 1924 ROBERT I. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1924

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1920, to Aug 7th, 1924, that I last saw h[illegible] alive on Aug 7th, 1924, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) yrs. 15 mos. — ds.

CONTRIBUTORY (Secondary) Asthenia —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Gustav Gothman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
~~Bet. Dad~~ Laurel Cemetery	Aug. 10 1924
20 UNDERTAKER Jno. M. Johnson	ADDRESS 1234 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec —8-24-14—M. & T.—2000 Bks.

D 55961

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55961

CERTIFICATE OF DEATH.

64

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 Druid Hill Ave. St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rudolph Watts, Dr.

(Residence in Baltimore: No. 2138 Druid Hill Ave. 52 yrs. 10 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Sept. (Month) 30 (Day), 1868 (Year)

7-AGE, 52 yrs. 10 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Hotel
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Waiter

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Robert Watts

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary J. Freeden

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie L. Watts (Wife)

(Address) 2138 Druid Hill Ave.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 29 1921, to Aug. 5 1921, that I saw h.. alive on Aug. 1921, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs.....mos. 6 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) ....yrs. 6 mos.....ds.

(Signed) W. V. Cox M. D.

Aug. 6 1921. (Address) 513 Mosher St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs.....mos.....ds. In the State ....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cemetery

DATE OF BURIAL. Aug. 8..., 1921

20-UNDERTAKER Jno. M. Johnson

ADDRESS 1234 Etting St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Care important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55962

CERTIFICATE OF DEATH.

87 D 55962

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View WARD 5)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Silas Corprew

(a) RESIDENCE. NO. 1236 Orleans St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norfolk, Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, New City Hospital

15 Filed AUG 8 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 6 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1921 to August 6, 1921, that I last saw h alive on August 6, 1921, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.

8/8/ 1921 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gilbury Cemetery aug 8.	1921

20 UNDERTAKER: Milton Davis 317 N Eden St ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55963

CERTIFICATE OF DEATH.

REGISTERED NO. 8

D 55963

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2309 E. Federal ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Skuhr

(a) RESIDENCE. NO. 2309 E. Federal ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John H. Skuhr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Helen A. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John H. Skuhr 2309 E. Federal

15 Filed AUG 8 - 1921 [illegible] Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 19 , to Aug 7, 1921.

(that I last saw h[illegible] alive on Aug 7 19 .

and (that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Enteritis (Convulsions)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank Ayd, M. D.

Aug 7, 1921 (Address) 2005 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem DATE OF BURIAL Aug 8 1921

20 UNDERTAKER Philip Henrig ADDRESS Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55964

CERTIFICATE OF DEATH.

55-001 D 55964

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3103 Oakfield Ave 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. B. Pitman

(Residence in Baltimore: No. 3103 Oakfield Ave St. 8yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word.) Married.

6-DATE OF BIRTH. May 26 1850
(Month) (Day) (Year)

7-AGE 71 yrs. 2 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Mint

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. W. F. Pitman

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Lydia Lemmon

13-BIRTHPLACE OF MOTHER (State or Country). Portland Me.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. B. Pitman

(Address) 3103 Oakfield Ave

15- AUG 8-1921 [illegible]

Filed....., 191.. [illegible]
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 7, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 10 1921, to Aug. 7 1921, that I saw him alive on Aug. 6 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) R. C. Metcalf M. D.

Aug 8, 1921 (Address) 1903 W. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Lakemount Cemetery DATE OF BURIAL. Aug 9 1921

20-UNDERTAKER Pittman & Gore ADDRESS 723 N. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT RESIDENCE OF DECEASED is very important. See instructions on back of certificate.

Remarks

Had several phy. in one case. According to Dr. Metzger's brief mem had encephalitis lethargica. No history of any other abnormal condition.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55965

HEALTH DEPARTMENT—CITY OF BALTIMORE

15 | D 55965

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene STS. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Stewart Smith

(a) RESIDENCE. NO. 607 Pitcher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 5 1921

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Stewart Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mary Smith (mother)
(Address) 607 Pitcher St

15 Filed AUG 8 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1921

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1921, to August 5, 1921, that I last saw him alive on August 5, 1921, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Pre-maturity
(3-4 weeks forlen)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Syphilis (?)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

8-6, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	ADDRESS
20 UNDERTAKER	

AUG 6 1921

INFORMATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55966

CERTIFICATE OF DEATH.

104 D 55966

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. 1738 Bank St ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W Jewer

(a) RESIDENCE. NO. 1738 Bank St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Jewer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Yaeger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant James Jewer
(Address) 1738 Bank St

15 Filed AUG 8-1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 19 21

17

I HEREBY CERTIFY, That I attended deceased from Aug 5, 19 21, to Aug 6, 19 21,

that I last saw h— alive on Aug 6, 19 21,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Warren, M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

DATE OF BURIAL: Aug 8 19 21

20 UNDERTAKER: M B Callender

ADDRESS: Bond & Ann Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

CAUSE OF DEATH in p... TION is very important. See instructions on back of ... ck of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55967

D 55967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hosp. 5 X 37 REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Randall

(a) RESIDENCE. No. Lewis St. New Orleans WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Randall

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer U4

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hosp Records
(Address)

15 Filed AUG 8-1921 ROBERT E. BEAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August. 6. 1921

17 I HEREBY CERTIFY, That I attended deceased from April 27. 1921. to Aug. 6, 1921. that I last saw him alive on Aug 6, 1921, and that death occurred, on the date stated above, at 7:45 Am.

The CAUSE OF DEATH* was as follows:

General Paralysis (4th Stage)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Injection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & serological findings

(Signed) W. J. Dorsett, M. D.

. 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetary	Aug 8 1921
20 UNDERTAKER	ADDRESS
Chas C. Bailey	1427 Jefferson

Before signing, READ CAREFULLY. Supplies must be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 55968

D 55968

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4818 Rendale Ave (ST.) 28 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Geage

(a) RESIDENCE NO. 4818 Rendale ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Millie Geagel

6 DATE OF BIRTH (month, day, and year) Feb 13 - 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 166

(b) General nature of industry, business, or establishment in which employed (or employer) John E. Hurst

(c) Name of employer City

9 BIRTHPLACE (city or town) ..... (State or country)

PARENTS

10 NAME OF FATHER Stephen Geagel

11 BIRTHPLACE OF FATHER (city or town) City (State or country) Schumberg

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) City (State or country)

14 Informant Mrs Millie Geagel (Address) 4818 Rendale

15 Filed AUG 8 - 1921 Registered

ROBERT J. REUTER

Special Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1921

17

I HEREBY CERTIFY, That I attended deceased from June 1st, 1921, to Aug 7th, 1921, that I last saw him alive on Aug 7th, 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? X Ray.

(Signed) A. C. Legum M. D.

1921 (Address) 4709 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Aug. 9 1921

20 UNDERTAKER W. L. Tuckwell Co

ADDRESS Walbrook

mation should be entirely supplied. Avoid abbreviations. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 55969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 D 55969

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pier 2 Clinton Street ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert B Simmons

(Residence in Baltimore: No. 801 S 6th Street St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, October 29 1893
(Month) (Day) (Year)

7-AGE, 27 yrs. 9 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Foreman
(b) General nature of industry, business, or establishment in which employed (or employer)..... of laboreres

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, J W L Simmons

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Schumacher

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James C Simmons

(Address) 810 S Clinton Street

15- Filed AUG 8 - 1921 191... ROBERT I KRAUSE Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 5 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigath (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) investigation and that said deceased came this death on the day stated above.

The CAUSE OF DEATH* was as follows:

accidental drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Gue Coroner M. D.

(Address) 1800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Aug 8 1921.
20-UNDERTAKER H. Sander & Sons	ADDRESS 1700 Flat St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If less than 1 day, hours or minutes must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 55970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55970

CERTIFICATE OF DEATH.

REGISTERED NO. 154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 S Linwood Ave ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wahl

(a) RESIDENCE NO. 117 S. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Wahl

6 DATE OF BIRTH (month, day, and year) March 16, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home yd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Konrad Greb.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Kratz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Wahl (Address) 112 S. Linwood ave

15 Filed AUG 8-1921 ROBERT J. REUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 21, to Aug 3, 1921, that I last saw her alive on Aug 5, 1921, and that death occurred, on the date stated above, at 11 45 A. m.

The CAUSE OF DEATH* was as follows:

Senilitis,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infirmities

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Ingler M. D.

, 19 (Address) 2938 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Aug 8 1921

20 UNDERTAKER H. Sander & Son — ADDRESS 1710 Eutaw

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55971

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 N. Belnord Ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredericka M. Hagedorn

(a) RESIDENCE. NO. 401 N: Belnord Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Gerhard Hagedorn

6 DATE OF BIRTH (month, day, and year) Apr 2nd 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Buddemeier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Regina Altvogt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Regina Hagedorn
(Address) 401 N: Belnord Ave

15 Filed . 19 Registrar

A1198-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1921, to Aug 7, 1921, that I last saw her alive on Aug 6, 1921, and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Exhaustion

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. S. Neer, M. D.

8/8/21 (Address) 405 S Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Aug 11 1921
20 UNDERTAKER	ADDRESS
J Kenny & Co	2008 Eutaw St

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

(James W Murray)

149904) 55972 HEALTH DEPARTMENT—CITY OF BALTIMORE 1200 55972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 14 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Murray

(a) RESIDENCE NO. 1814 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Murray.

6 DATE OF BIRTH (month, day, and year) June 1, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	39	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bell boy.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Johns Hopkins Hospital Baltimore

15 Filed AUG 8 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1921, to Aug 6, 1921, that I last saw him alive on Aug 6, 1921, and that death occurred, on the date stated above, at 10:30 am m.

The CAUSE OF DEATH* was as follows:

General peritonitis

(duration) yrs. 2 mos 14? ds.

CONTRIBUTORY (Secondary) Anemia + Intestinal perforation

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Aug 6, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Operative findings

(Signed) Jay McLean, M. D.

8-6. 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ind Auburn Cem. DATE OF BURIAL Aug 9 1921

20 UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

Information should be carefully supplied. AGE should be stated CAREFULLY. Exact statement of each item may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55973

CERTIFICATE OF DEATH.

29 D 55973

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tb Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Johnson

(a) RESIDENCE. NO. 586 Baker St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 204

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Roanoke City Va

PARENTS

10 NAME OF FATHER Daniel Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Municipal Hosp. (Address)

15 Filed AUG 8-1921 ROBERT J. BRAUER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 22 1921 to Aug 7 1921

that I last saw him alive on Aug 7 1921

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonic Phthisis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jmd Auburn Cem	Aug 8 1921.
20 UNDERTAKER	ADDRESS
Geo H. Holland	1618 Pennsylvania Ave

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than one day, hours or minutes must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 55974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 55974

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 N Arlington Ave ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Sewell

(Residence in Baltimore: No. 220 N Arlington Ave St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	colored	widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1853 (Year)

7-AGE, 68 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... do

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Sewell

(Address) 103 N Carlton St

15-

Filed Aug 9 1921, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 6 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1921, to Aug 6 1921, that I saw her alive on Aug 5 1921, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

I
Acute Gastritis
Duration

CONTRIBUTORY (Secondary) Acute Dilitation
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E Edward E Fisher M. D.

Aug 7 1921 (Address) 612 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Aug 8 1921
20-UNDERTAKER Brown & Tucker & Schroder	ADDRESS 1140

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Plater

D 55975 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55975

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 109 arch st. St. 4 Ward) REGISTERED NO. C 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Plater

(Residence in Baltimore: No. 109 arch st. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Colrd	Sigle

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. .....ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nonny
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto city

PARENTS.

10-NAME OF FATHER, Harry Plater

11-BIRTHPLACE OF FATHER (State or Country). Balto City

12-MAIDEN NAME OF MOTHER Pauline Chapman

13-BIRTHPLACE OF MOTHER (State or Country). Balto city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Yates

(Address) 109 Arch St.

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.

8-1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...August..... 7 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an .....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said .....Inquest, autopsy or inquiry.) found that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Foot Trouble

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) ..... M. D.
(Coroner)

8-8-, 1921 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral Cem.	Aug 9, 1921
20-UNDERTAKER	ADDRESS
Edw. E. Cruze	102 E. Mulberry

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55976

CERTIFICATE OF DEATH.

58 ✓ D 55976

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 S. Clinton ST.: 36 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Dorothy Leonard

(Residence in Baltimore: No. 718 S. Clinton St.: 64 yrs., 4 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, A WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. November 1, 1856
(Month) (Day) (Year)

7-AGE. 64 yrs. 9 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework 03
(b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Frank Poerringer

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Kunigunda Goetz

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicholas Leonard

(Address) 718 S. Clinton St.

15-

Filed 1921

Robert P. Harrison,
Burial Permit Clerk. Registrar.

8-1921

R.—Every item of information should be given, as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 6th, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1921, to August 5th 1921, that I saw her alive on August 5th 1921, and that death occurred, on the date stated above, at 5:25 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 4 ds.

(Signed) Geo. J. Tollinchi M. D.

Aug. 6, 1921. (Address) 806 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Sacred Heart Cem.

DATE OF BURIAL. Aug. 9th, 1921.

20-UNDERTAKER Lilly and Zirkin

ADDRESS 403 S. Wolfe St.

D 55977

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55977

CERTIFICATE OF DEATH.

56

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1207 W. Hughes St. WARD) 20

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Forman

(Residence in Baltimore: No. 286 E. Lee St. 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. January 1, (Month) (Day) 1889 (Year)

7-AGE. 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Va

PARENTS.

10-NAME OF FATHER. John Smith

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Annie Jones

13-BIRTHPLACE OF MOTHER (State or Country). North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Smith
(Address) 1207 W. Hughes St.

15-
Filed Aug 8, 1927 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 7, 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) J. Edw. Schadt M. D.
(Coroner)
Aug 7 1927 (Address) 1743 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn
DATE OF BURIAL, Aug 9, 1927

20-UNDERTAKER, R. L. Durham
ADDRESS 1144 W. Fa St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

468-1927

Spec.—1-10-21—M&T—1500 Bks.

D 55978

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55978

CERTIFICATE OF DEATH.

X 45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (ST.) 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Earl Ruble

(a) RESIDENCE NO. R. D. #1 Parkersburg W. Va. (ST.)

(Usual place of abode)

WARD Parkersburg W. Va.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr James E Ruble father R. D # 1 Parkersburg W Va.

6 DATE OF BIRTH (month, day, and year) June 12-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Operator 086

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER James E Ruble

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Anna C Everhart.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant (Address) Johns Hopkins Hospital Records

15 Date 8-8-1921, 19 Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1921, to Aug 8, 1921, that I last saw him alive on Aug 8, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cerebellar Tumor.
Endothelioma

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of Aug 8 '21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emile Holman, M. D.

. 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkersburg W. Va. DATE OF BURIAL 8 9 21

20 UNDERTAKER H E Hughes ADDRESS 114 St Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. If unknow
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 55979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55979

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 Kennedy ave ~~St.~~; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anna Kelly

(a) RESIDENCE. NO. 1923 Kennedy ave ~~St.~~ WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of Washington Kelly

6 DATE OF BIRTH (month, day, and year) about 80 years

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown unknown

14 Informant Mrs. M. Lee (Address) 1211 E. Broadway

15 Filed Aug 8 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 6, 1921, that I last saw her alive on Aug 6, 1921, and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Diarrhea

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Pleasant Valley Carroll County, Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Albert E. Hesser, M. D.

, 19 (Address) 1301 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	8/9/21 19
20 UNDERTAKER	ADDRESS
H. E. Wright	411 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. Physician's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

14780. D 55980

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 - 1 D 55980

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 98 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Peters

(a) RESIDENCE NO. 600 N. Washington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 2 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elisa Peters.

6 DATE OF BIRTH (month, day, and year) Nov. 12 1893.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	27	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) ? 031

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) South America ?

PARENTS

10 NAME OF FATHER Martin Peters ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) South America ?

12 MAIDEN NAME OF MOTHER Helen Aeome ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South America ?

14 Informant (Address) John Hopkins Hospital Records

15 Filed AUG 9 - 1921 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1921, to August 7, 1921, that I last saw him alive on August 7, 1921, and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

Cellulitis L Calf Leg.

(duration) .... yrs. .... mos 14 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) .... yrs. .... mos. 4 ds.

18 Where was disease contracted if not at place of death? In Balto Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry M. Thomas Jr., M. D.

8-9-21, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Hoods	Aug 10 1921
20 UNDERTAKER MESSRS. N. S. FINK FUNERAL DIRECTORS 1005 W. PRATT STREET	ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55981

CERTIFICATE OF DEATH.

45 D 55981

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 South Mount St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizebeth Steinnemann

(Residence in Baltimore: No. 205 S. Mount St. St.; 39 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June 10 (Month) 14. (Day) 1847 (Year)

7-AGE. 39 yrs. 1 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Steinnemann

11-BIRTHPLACE OF FATHER (State or Country), Baden Mass.

12-MAIDEN NAME OF MOTHER, Adalin Singraft

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Knell

(Address) 917 Columbia Ave

15. AUG 9-1921 ROBERT J. BRAUER

Filed....., 191..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7th (Month) (Day) – 25 & Observed. 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1921, to July 7 1921, that I saw her alive on July 7 1921, and that death occurred, on the date stated above, at 2.55 p. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Bladder

(Duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. H. Philips M. D.

Aug 9, 1921 (Address) 2300 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Aug. 10th, 191...

20-UNDERTAKER Knell & Son ADDRESS 917 Columbia Ave

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

55982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 55982

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 N. Bond ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy M. Glover

(a) RESIDENCE. NO. 934 N. Bond ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 15 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jos R Glover

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ida Lambdin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs Glover 934 N. Bond st

15 Filed AUG 9 — 1921, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1921, to Aug 8, 1921, that I last saw h[illegible] alive on Aug 8, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Convulsions ——— 8 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion ? hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Benj. L. Hartman, M. D.

(Address) 1216 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Aug 9 1921

20 UNDERTAKER: Henry Lutz — ADDRESS: 1007 N. Bond

Burial Permit Issued

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Intestinal Indigestion.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 D 55983

D 55983

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Anthony ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Leist

(a) RESIDENCE. No. 1424 Anthony ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? 52 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12/1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Novey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant William Leist

(Address) 1424 Anthony St

15 Filed AUG 9 - 1921 19 ROBERT E KRAUTER Registrar

Burial Cough Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10th 19 21, to Aug 7th 19 21.

that I last saw h.. alive on Aug 6th 19 21.

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Hemorrhage

(duration) yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. ..... mos. ..... ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. S. Lucas M. D.

Aug 7. 19 21 (Address) 1806 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A. A. County	Sept 10 1921
20 UNDERTAKER Frank A. Fink	ADDRESS 915 N. Gay St

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Haransky.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

146 D 55984

CERTIFICATE OF DEATH.

D 55984

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Hyman Haransky

(a) RESIDENCE. No. 38 South Eden ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? 7 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 25, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cap-maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: David Haransky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Eva ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hospital Records Mercy Hospital

(Address)

15 Filed AUG 9 - 1921 19 ROBERT J. BRAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1921, to Aug 9, 1921, that I last saw him alive on Aug 9, 1921, and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Abdominal Peritonitis

(duration) (several months) yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Aug 3, 1921

Was there an autopsy? U. S. A. Autopsy

What test confirmed diagnosis? Signs & Symptoms

(Signed) John J. Corwin M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Riverdale	Aug 9- 1921

20 UNDERTAKER: Jack Lewis ADDRESS 1414 E. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D55985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 55985

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 W Belvedere Ave. 27 WARD)

2-FULL NAME Mary M. J. Bowen

(a) RESIDENCE No. 225 W Belvedere Ave. St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Charles H Bowen

6 DATE OF BIRTH (month, day, and year) June 15 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry A Schmeis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Voss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles H Bowen (Address) 225 W Belvedere Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1920, to Aug 8, 1924, that I last saw h[illegible] alive on Aug 8, 1924, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Jan. 1920

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) Frederick R. Dean, M. D.

, 19 (Address) 1827 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catonsville Lutheran DATE OF BURIAL Aug 10 1924

20 UNDERTAKER Williamson & Son ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH PEN AND INK. AGE should be stated EXACTLY. PHYSICIANS should be careful in filling out the AGE. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified, so that it may be plain terms, so that it may be properly classified. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55986

40 D 55986

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 Madison Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L McDannald

(a) RESIDENCE. NO. 1100 Madison Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida V McDannald

6 DATE OF BIRTH (month, day, and year) Nov 16 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) 025

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrisburg Pa

PARENTS

10 NAME OF FATHER Charles R McDannald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bath Co Va

12 MAIDEN NAME OF MOTHER Ellen Mayse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harrisburg Pa

14 Informant (Address) Mrs. N. E. McDannald Reisterstown Md

15 Filed AUG 9 1921, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1921

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1921, (to) Aug 8, 1921, that I last saw him alive on Aug 8, 1921, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pylorus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Toxemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of May 26-1921

Was there an autopsy? No

What test confirmed diagnosis? X ray - blood - Test Meal

(Signed) Geo McLean, M. D.

19 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebb Springs Va Aug 9

DATE OF BURIAL 1921

20 UNDERTAKER: William Cook & Co

ADDRESS Reisterstown Md

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55987 (1)

D 55987 (2)

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1125 S. Clinton ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Appel

(a) RESIDENCE. No. 1125 S. Clinton ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine Appel

6 DATE OF BIRTH (month, day, and year) Jan. 7-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	—	1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired DH

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Appel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Katharine Appel (Address) 1125 S. Clinton St.

15 Filed AUG 9 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 3rd, 1921, to Aug 7th, 1921, that I last saw him alive on August 6th, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) David W. Jones, M. D.

8/8/1924 (Address) 1013 N. Edwards Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Aug 9 1921

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager St

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55988

CERTIFICATE OF DEATH.

115 091 D 55988

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Edith Duer

(Residence in Baltimore: No. 211 E. Biddle St.; 68 yrs., 6 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single.

6-DATE OF BIRTH, June (Month) 6 (Day), 1853 (Year)

7-AGE. 68 yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Duer

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Henrietta Adgate

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Ro. Carter

(Address) Washington, Maryland

15- Filed AUG 9 - 1921, 191... ROBERT S. BRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 9, (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1921, to Aug 9, 1921, that I saw h[illegible] alive on Aug. 7, 1921, and that death occurred, on the date stated above, at 7.50 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Operation - Cholecystostomy

(Duration) ....yrs. ....mos. 4 ds.

(Signed) Frank Deborthen Jr. M. D.

Aug 9, 1921. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 5 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Womans Hospital

Former or usual residence 211 E. Biddle St.

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, 9-11, 1921

20-UNDERTAKER George W. Jenkins Stone Co

ADDRESS McCulloh & Orchard

N.B.—Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 55989

D 55989

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #607-N-Carey Street ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bessie Trusil

(a) RESIDENCE. NO. #607-N-Carey-Street ST.. 16 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 74 yrs. 11 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (None)

6 DATE OF BIRTH (month, day, and year) Aug-13-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Gettysburg Penna.

PARENTS

10 NAME OF FATHER Philip J.Trusil

11 BIRTHPLACE OF FATHER (city or town) not known
(State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Grace.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. EmmaP.Mullikin(sister)
(Address) #607-N-Carey-St. City.

15 Filed AUG 9 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6. 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1. 1921. to Aug-6. 1921.

that I last saw her alive on Aug 6-21 19 .

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Medical Staff, M. D.

Aug 9th 19 (Address) 607N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug-9-21 19

20 UNDERTAKER STE[illegible] COMPANY ADDRESS 108 W. [illegible] AVE.
(Signature [illegible], Business)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

55990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

110 D 55990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 838 N Stricker St. (Ward) 16

2-FULL NAME Mary Levin

(a) RESIDENCE. (No.) 838 N Stricker St., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. 10 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Hyman Levin

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Ida Entelbaum

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Hyman Levin
(Address) 1411 Eutaw St

15 Filed AUG 9 1921, 19 ___ ROBERT P. KRAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/8, 1921, to 8/9, 1921, that I last saw her alive on 8/8, 1921, and that death occurred, on the date stated above, at 10.45 m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ingestion food poisoning (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Lynn Cox, M. D.

8/9, 1921 (Address) 1530 N Chapel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Montefiore Cemetery	8/9 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE mation should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55991 — D 55991

CERTIFICATE OF DEATH.

X 45

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) St. Joseph's Hospital (St.;) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister M. Virginia (Bridget McCaffrey)

(a) RESIDENCE. NO. St. Joseph's Hospital ST., WARD. Oklahoma

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? 39 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE — Years: 52 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious 065

(b) General nature of industry, business, or establishment in which employed (or employer): Nun

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Mr. McCaffrey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Records at St. Joseph's Hosp. Caroline & Hoffman Sts.

15 Filed AUG 9 - 1921, 19... Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1921, to Aug 8, 1921, that I last saw h.er alive on Aug 8, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Thyroid

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) S. W. Kaurey, M. D.

, 19 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Aug 10 1921

20 UNDERTAKER: Henry Hoerdt Son — ADDRESS: 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should be careful that information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be CAUSE OF DEATH in plain terms, so that it may be of certificates. See instructions on back of certificates. TION is very important.

WRITE PLAINLY, WITH UNFADING INK

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. *See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 55992

55992

CERTIFICATE OF DEATH

X 104

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 705 Light St St. 27 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Harry B Chapman

(Residence in Baltimore: No. 705 Light St St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
male	white	single

6 DATE OF BIRTH April (Month) 25 (Day), 1921 (Year)

7 AGE ..... yrs. 3 mos. 8 ds. | If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ..... nt any boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Harry B Chapman

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Susan Dempsey

13 BIRTHPLACE OF MOTHER (State or country) Scotland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Susan Chapman

(Address) 705 Light St

15 Filed AUG 9 - 1921, 191 ... Registrar ... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August (Month) 8 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1921, to Aug 8, 1921, that I saw h.... alive on Aug 7, 1921, and that death occurred, on the date stated above, at 7: a m.

The CAUSE OF DEATH* was as follows:

(a) .....
(b) Toxemia
(c) .....
(d) .....

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (SECONDARY) Ulcerative Colitis (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) G Fenton M. D.

8-9-21, 191..... (Address) 705 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Virginia

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
London Park	Aug 9, 1921
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

D 55993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 79 D 55993

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 251 S Maderia Street ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Levie

(Residence in Baltimore: No. 251 S Maderia Street St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH. August (Month) 6 (Day) 1889 (Year)

7-AGE.	If LESS than 1 day,
32 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: platform clerk
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country). balt imore md

PARENTS.

10-NAME OF FATHER. Joseph Levie

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Mary Kalvoda

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vidla Bannach

(Address) 251 S Maderia St

15- [redacted] Registrar.

Filed AUG 9-1921., 191.. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 7 (Day) 1921 (Year), 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigath (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) investigation find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart trouble

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Henry Gau M. D. (Coroner)

8/8/21 1921 (Address) 1800 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary

DATE OF BURIAL. aug 10, 1921

20-UNDERTAKER John M Weber

ADDRESS 1803 Bank St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

55994

14973 D 55994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55994

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Baby Mcnamara.

(a) RESIDENCE NO. Herman Cottenden Nurse ST., 837 Holland St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) — (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Johns Hopkins Hospital (Address) Baltimore

15 Filed AUG 9 - 1921 ROBERT I. LYNCH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1921, to Aug 6, 1921, that I last saw h alive on Aug 6, 1921, and that death occurred, on the date stated above, at 5-30 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Dr

What test confirmed diagnosis? None

(Signed) W D Warren, M. D.

8-6-21 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 1921

20 UNDERTAKER

ADDRESS AUG

Commissioner Health

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 55995 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55995

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 115 W. Henrietta ST. 23 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Jones

(Residence in Baltimore: No. 115 W. Henrietta St. 5 yrs., mos. da.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, unknown (Month) (Day) 18[illegible] (Year)

7-AGE, 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie Scott

(Address) 115 W. Henrietta St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

JUG 2-1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Contributory

(Duration) yrs. mos. ds.

(Signed) C. E. Yates M. D.
(Coroner.)

Aug 9 1921, 191... (Address) 143 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Aug 10, 1921
20-UNDERTAKER	ADDRESS
J. L. Grounds Son	768 W. Montgomery

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 55996 HEALTH DEPARTMENT—CITY OF BALTIMORE D 55996

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 22 ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Hagan

(a) RESIDENCE. NO. ~~Unknown~~ 633 N. Barre ST.; ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 640

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, New City Hospital.

15 Filed AUG 9 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8 1921

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1921 to August 8, 1921 that I last saw him alive on August 8, 1921 and that death occurred, on the date stated above, at 1:50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Mahrill M. D.

8/9/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 10 21
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS mation should be carefully supplied. AGE should be s CAUSE OF DEATH in plain terms, so that it may be pro TION is very important. See instructions on back of cert PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPA- properly classified. of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 55997

D 55997 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E Montgomery ST.: 7W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdaleine Schier

(a) RESIDENCE. No. 117 E. Montgomery ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

6a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John Schier

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	62	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Ort

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Augusta Hamel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Schier (Address) 117 E Montgomery

15 Filed Robert P. Harrison, Registrar

AUG 9-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6-1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 28. 1919, to Aug 6- 1921, that I last saw her alive on Aug 5 1921, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 15 ds.?

CONTRIBUTORY (Secondary) Adenon Carcinoma

Brast (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) L. L. Burston, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL Aug 10 1921

20 UNDERTAKER E J Bunning & Son — ADDRESS 1938 E Lafayette

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of_ certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 55998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55998

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 N Castle ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Umplely

(a) RESIDENCE. NO. 1826 N Castle ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Umplely.

6 DATE OF BIRTH (month, day, and year) June 20 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Margaret Gantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Catherine Umplely (Address) 1826 N Castle

15 Filed ..... 19 ..... Registrar

AUG 9-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 . 1921 . to Aug 6 . 1921 .

that I last saw h[illegible] alive on Aug 6 . 1921 .

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.
Myocarditis -

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Hyde, M. D.

8/8. 1921 (Address) 100 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 10 1921
20 UNDERTAKER	ADDRESS
E J Deming & Son	1938 E Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Pazderesky)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 55999

79 ✓ D 55999

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 Quick Ark ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Pazderesky

(a) RESIDENCE. No. 32 Quick Ark ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Pazderesky

6 DATE OF BIRTH (month, day, and year) Dec. 13 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER W. Seba

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant John Pazderesky (Address) 32 Quick Ark.

15 Filed ..... 19 ..... Robert F. Burkhardt Registrar

Burial Permit Clerk

AUG 9 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 19 21 to Aug 6, 19 21

that I last saw h.. alive on Aug 6, 19 21.

and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Endocarditis

Uremia (duration) yrs. 1 mos. ds.

CONTRIBUTORY Arteriosclerosis

(Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. M. Hurd M. D.

Aug 7, 19 21 (Address) 1000 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 10, 1921
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	147 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.56000

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 56000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 68 E. Heath St. Ward 23) REGISTERED No. 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice M. Horist

(a) RESIDENCE. No. 68 E. Heath St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? 79 yrs. 4 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Patrick A. Horist

6 DATE OF BIRTH (month, day, and year) March 17th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79.	4	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Duties
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER John Wilderman
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland
12 MAIDEN NAME OF MOTHER Unknown.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Cecelia Seltzer
(Address) 68 E. Heath St.

15 Filed Aug 9 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10th 1921, to August 7th 1921.
that I last saw her alive on August 6th 1921.
and that death occurred, on the date stated above, at 12. P.M.
The CAUSE OF DEATH* was as follows:

Chronic Cortic Regurgitation of Heart (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) General Anasarca (duration) — yrs. — mos. 1½ ds.

18 Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Findings
(Signed) Harry Weibel M.D.
8/8, 1921 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery.	Aug 10th 1921
20 UNDERTAKER	ADDRESS
Mr. & Mrs. John W. Teufel & Son.	501 W. Fayette

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... TION is very important. See instructions on back of certificates.

AUG 9-1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56001 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56001

CERTIFICATE OF DEATH.

REGISTERED NO. 78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2651 Penna Ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha K. Williams

(a) RESIDENCE. NO. 2651 Penna Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? 30 yrs. 11 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Williams

6 DATE OF BIRTH (month, day, and year) Sept 9th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30 yrs	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Newell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Henry Beck
(Address) 1601 Penna Ave

15 Filed ..... 19 .....

Robert P. Harrison, Registrar

Burial Permit Clerk.

AUG 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1921, to August 8th, 1921, that I last saw h[illegible] alive on August 8th, 1921, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Wm. J. Sullivan, M. D.

Aug. 9. 1921 (Address) 1701 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Aug 11 1921
20 UNDERTAKER	ADDRESS
J A Rems Co	1611 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

(Crane)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56002

D 56002

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1033 Rice ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Crane

(a) RESIDENCE. NO. 1035 Rice ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bellay Harford Co Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant William Jones

(Address) 1321 Upton St

15 Filed AUG 10 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 6 . 1921 . to Aug 7 . 1921 .

that I last saw her alive on Aug 7 . 1921 .

and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James L Hooper, M. D.

8-9. 1921 (Address) 5146 E 28th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Aug 10 1921

20 UNDERTAKER Daniel Easton — ADDRESS 916 Pa ave

X. B. WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56003 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56003

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH USPHS Hosp.#56

CITY OF BALTIMORE: (No. #56 Ft.McHenry,Balto.Md. ST., 24 WARD)

2-FULL NAME Aquilino B. Perez

(a) RESIDENCE NO. USPHS Hosp.#56,Ft.McHenry ST., 8a WARD Baltimore,Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs.Aquilino B. Perez

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
40	-	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T.Rosenbrock,Registrar

(Address) USPHS Hosp.#56 Baltimore,Md.

15 Filed AUG 10 1921, 19... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug.8, 1921.

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1921 to Aug.8 1921.

that I last saw him alive on August 8, 1921.

and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis,chronic

May 19,1921 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Omentum and Lymph glands

May 19,1921 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of --

Was there an autopsy? no

What test confirmed diagnosis? Clinical report

(Signed) Thomas B. Bryan M. D.

Senior Surgeon USN

19 (Address) USPHS Hosp.#56,Balto.MD

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetry

DATE OF BURIAL Aug 10 1921

20 UNDERTAKER Sol Leinser

ADDRESS 127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Novikoff)

D 56004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56004

CERTIFICATE OF DEATH.

78

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1204 St Matthews ST.: 5 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rive Novikoff Rebecca Novick

(a) RESIDENCE. NO. 1204 St Matthews ST.. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) dont Know 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Barnell Richmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Isaac Novikoff (Address) 1204 St Matthews St

15 Filed AUG 10 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to Aug 8, 1921, that I last saw h[illegible] alive on Aug 8, 1921, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis & Pulmonary Tuberculosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael S Hirsh M.D. M. D.

, 19 (Address) 2360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL Aug 10. 1921

20 UNDERTAKER Mut Funeral — ADDRESS 1178 Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Archi-*

DR. MICHAEL A. ABRAMS
2360 EUTAW PLACE
OFFICE CONSULTATIONS: 5 TO 7 P. M., AND BY APPOINTMENT
REG NO 526

NAME

ADDRESS

R

This is to certify that The name
" Rev Monroe as made mk
in the same capacity
by me to the Father
Baltimore, Md, about
Rebecca Norris
is the parents
Sworn to before me this
23rd day of August, 1921.
Notary Public.

Subscribed and sworn to before me this
23rd day of August, 1921.

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely
pse," "Coma,""Con-
al," "Senile," etc.),
failure," "Hemor-
"Old age,""Shock,"
n a definite disease
Always qualify all
or miscarriage, as
RPERAL *peritonitis*,"
gical operation was
HS state MEANS OF
NTAL, SUICIDAL, or
h, if impossible to
: *Accidental drown-*
-accident; Revolver
ned by carbolic acid
e of the injury, as
ences (e. g., *sepsis*,
e head of "contribu-
atement of cause of
on Nomenclature of
on.)

HER STATEMENTS
.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles;*

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56005

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST.; 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Humbert.

(a) RESIDENCE. NO. Taneytown, Md. ST., WARD. Taneytown Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. D. M. Humbert.

6 DATE OF BIRTH (month, day, and year) 1865.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56 Yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Humbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Hospital Records (Address)

15 Filed ....., 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

AUG 1 01921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1921.

17 I HEREBY CERTIFY, That I attended deceased from July 25th, 1921, to August 9, 1921, that I last saw h. alive on August 9, 1921, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with secondary metastases to Liver.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7/28/21

Was there an autopsy? no.

What test confirmed diagnosis? Lab. exam. of specimen

(Signed) Cyrus P. Koons, M. D.

, 19 (Address) Community Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Taneytown Md	Aug 10 1921
20 UNDERTAKER W M Routson	ADDRESS Greenmount

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION

Spec.—1-10-21 M&T 1500 Bks.

D 56006

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56006

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1373 Woodyear ST. 15 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Son Cook Catherine Cook

(a) RESIDENCE NO. 1378 Woodyear ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6 /21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Irvin Cook
11 BIRTHPLACE OF FATHER (city or town) Balt Co
(State or country) Md.
12 MAIDEN NAME OF MOTHER Catherine Carter
13 BIRTHPLACE OF MOTHER (city or town) Balt Co
(State or country) Md

14 Informant Catherine Carter
(Address) 1373 Woodyear

15 Robert P. Harrison, Registrar
Burial Permit Clerk.
AUG 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 6 ., 19 21 ., to Aug 9 . 19 21 .
that I last saw h.. alive on Aug 9 . 19 21 .
and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:
Premature Birth.

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) William Frey M. D.
Aug 9 . 19 21 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters — DATE OF BURIAL Aug 11 1921

20 UNDERTAKER Harman & Wright — ADDRESS 1641 McCulloh

MARGIN RESERVED

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56007

CERTIFICATE OF DEATH.

119

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 409 Deaver St (St.) 12 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Irins

(a) RESIDENCE. (Usual place of abode) No. 409 Deaver St. St., Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE 58 Years — Months — Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 03

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Balt-City

PARENTS

10 NAME OF FATHER Jacob Rindall

11 BIRTHPLACE OF FATHER (city or town) (State or country) born in Baltimore

12 MAIDEN NAME OF MOTHER Georgianna Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Co

14 Informant Samuel H Irins

(Address) 409 Deaver St—Balt-City

15 Filed AUG 10 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1921

17 I HEREBY CERTIFY, That I attended deceased from June 24 1921, to Aug 7th 1921, that I last saw h[illegible] alive on Aug 7th 1921, and that death occurred, on the date stated above, at 7 A.M. P.M.

The CAUSE OF DEATH* was as follows: Acute Pancreatitis Hemorrhagic and Cardiac Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism & Hardening of (duration) 3 yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm H Hall, M. D.

, 19 (Address) 1926 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Irvine Cem Forestown Md

DATE OF BURIAL: Aug 11 1921

20 UNDERTAKER: Mrs R A Elliott

ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION on back of certificates. See instructions on back of certificates. See instructions on back of certificates. See instructions

Spec.—1-10-21—M&T—1500 Bks.

D 56008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56008

CERTIFICATE OF DEATH.

74

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Williams

(a) RESIDENCE NO. 902 Pear St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	singl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home-work

(b) General nature of industry, business, or establishment in which employed (or employer) Homework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lic in Balt 30 years

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Johns Hopkins Hospital Records.

15 Filed . 19 Registrar

AUG 10 1921 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 . 1921 . to Aug 8 . 1921 .

that I last saw h alive on Aug 8 . 1921 .

and that death occurred, on the date stated above, at 6:45 p m.

The CAUSE OF DEATH* was as follows:

Hypertensive
Cardiovascular Renal
Myocardial insufficiency

(duration) yrs. 5 mos 5 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clin. Exam + Lab findings

(Signed) Henry M. Thomas jr M. D.

8.9. 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Aug 12. 1921

20 UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56009

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Kelley

(a) RESIDENCE NO. 1629 E. Monument ST. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	~~Col~~	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10-21

7 AGE	Years	Months	~~Days~~	If LESS than 1 day, hrs or ... min.
			3 wks	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Handy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice White

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed ... 19 ... Registrar

Robert F. Harrison,
Burial Permit Clerk

AUG 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1921, to Aug 8, 1921, that I last saw h Evelyn alive on Aug 8, 1921, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchi

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) W. Harrison, M. D.

8-9-1921 (Address) J H H

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Aug 10 1921

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56010

CERTIFICATE OF DEATH.

D 56010

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 Presstman ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Johnson

(a) RESIDENCE. NO. 410 Presstman ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chaney Johnson

6 DATE OF BIRTH (month, day, and year) June 24, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	81	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer - Ex-.

(b) General nature of industry, business, or establishment in which employed (or employer) Raising Family

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Spencer Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mikey White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant John W. Johnson (Address) 410 Presstman St

15 Filed ... 19... Robert P. Harrison, Registrar

AUG 10 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1921

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to Aug 9, 1921, that I last saw h[illegible] alive on Aug 9, 1921, and that death occurred, on the date stated above, at 2.15 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage 2nd

(duration) ... yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs, ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Nathan H Wright M. D.

(Address) 1704 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Aug 11 1921

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56011

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56011

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital Bay View. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Satterfield

(a) RESIDENCE. No. 1631 Hartford Avenue ST. City WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Satterfield

6 DATE OF BIRTH (month, day, and year) Sept. 4th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	--11	--2	/

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Street Cleaner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Satterfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Martha Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. K. A. Satterfield
(Address) 1631 Hartford ave

15 Date AUG 10 1921, 19

Robert P. Harrison,
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6 19 21

17 I HEREBY CERTIFY, That I attended deceased from August 4, 19 21, to August 6, 19 21, that I last saw him alive on August 6, 19 21, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

30 minutes. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

19 (Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery.	Aug. 10 '21
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave.

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56012

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2516 N. Fayette St (St.) 70 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Isabel Hoxter

(a) RESIDENCE. No. 2516 N. Fayette St. Ward. Stevenson Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 8 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chester Md.

PARENTS

10 NAME OF FATHER Thos. L. Hoxter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elen. Livingston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thos. L Hoxter.
(Address) 2615 N. Fayette St.

15 Filed Robert P. Harrison, Registrar
AUG 10 1921
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1921, to Aug 9, 1921, that I last saw her alive on Aug 9, 1921, and that death occurred, on the date stated above, at 5 20 6 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia
Tuberculosis - advanced

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac arrhythmia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cantalenen, M. D.

8/10, 1921 (Address) 2422 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stevenson Md.	Aug 11 1921
20 UNDERTAKER	ADDRESS
Harry N Hutzler	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56013 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56013

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 S Charles ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lewis

(a) RESIDENCE. NO. 819 S. Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 10 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 200

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Chas R Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Nellie Dowdy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mr Chas R Lewis

(Address) 819 S Hanover St.

15 Filed AUG 10 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 . 1921 . to Aug 9 . 1921 .

that I last saw h alive on Aug 9 . 1921 .

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Suspicion

(Signed) C Hamm M. D.

. 19 (Address) 112 S Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem.	Aug 10 th 1921
20 UNDERTAKER	ADDRESS
John J. Kirwan & Son	901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 56014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56014

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Gaem & Pratt sts. ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James F. Braden

(Residence in Baltimore: No. 649 W Lombard St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 24 (Day), 1862 (Year)

7-AGE, 61 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER, Mary V. Braden

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sol Goodyear

(Address) 27 S. W. Lafayette Ave

15-

Filed ....., 191.... Robert P. Harrison Registrar.

AUG 10 1921 [Burial Permit Clerk.]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy 24 hours (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know (Duration) yrs. mos. ds.

(Signed) W. K. Jorningham M. D. (Coroner.)

8-10-, 1921 (Address) 117 W. Davidge St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Balto Cemetery

DATE OF BURIAL, Aug 11, 1921

20-UNDERTAKER H. M. Routson

ADDRESS 230 N Green

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56015 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 56015

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 S Eden ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Smith

(Residence in Baltimore: No. 202 S Eden St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	

6-DATE OF BIRTH, Aug (Month) 7 (Day), 1921 (Year)

7-AGE, 4 hours ....yrs....mos....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John E Smith

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Alice Wagner

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E Smith

(Address) 202 S. Eden St.

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

AUG 10 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1921, to Aug 7 1921, that I saw her alive on Aug 7 1921, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs....mos....ds.

(Signed) Alb A Gagl M. D.

8/9/21, 191... (Address) 7 W Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Schwartzes Cem. DATE OF BURIAL, Aug. 10, 1921

20-UNDERTAKER Wm C. Black ADDRESS 927 N Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D 56016 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56016

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 707 P Penn) ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Edward Lee

(Residence in Baltimore: No. 707 P. Penn St St. 2 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct 6 (Month) (Day), 1883 (Year)

7-AGE, 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Car Cleaner
(b) General nature of industry, business, or establishment in which employed (or employer): B & O

9-BIRTHPLACE, (State or Country), Baltimore County

PARENTS.

10-NAME OF FATHER, Joseph Lee

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER, Catherine Pfaffenroth

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Lee

(Address) 707 P Penn St

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

AUG 10 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 9 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Lyon Farley (Coroner.) M. D.

Aug 10, 1921 (Address) 800 N Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery

DATE OF BURIAL, Aug 12, 1921

20-UNDERTAKER Geiler

ADDRESS 407 Pratt

D 56017

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56017

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 711 Linden Ave ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriet A. Harris

(Residence in Baltimore: No. 711 Linden Ave St.: yrs. 50 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1862 (Year)

7-AGE, ... 59 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Ross

(Address) 711 Linden Ave

15- Robert P. Harrison,

Filed ....., 191..... Burial Permit Clerk

AUG 10 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... August 7 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquest .....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ..... Jury .....
(Inquest, autopsy or inquiry.)

.....find that said deceased came to ..... her ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Organic heart disease .....

..... (Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no history

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. D. Hennessy M. D.
(Coroner.)

Aug. 8, 1921 (Address) 2502 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Aug 9 1921

20-UNDERTAKER, Samuel Hensley

ADDRESS 758 Edmondson Ave

Spec.—6-9-19—H. P. Co.— 1000 Blks.

D 56018 HEALTH DEPARTMENT—CITY OF BALTIMORE 094 D 56018

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 Dover St ward 1) ST.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Robinson

(a) RESIDENCE. No. 729 Dover St. ST.; WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Robinson

6 DATE OF BIRTH (month, day, and year): Nov. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51 years.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Caroline Co Virginia

PARENTS

10 NAME OF FATHER: Wm Henry Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Blanche Bowdley 729 Dover St.

15 Filed Robert P. Harrison Registrar

UG 10 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1. 1921. to Aug 7. 1921.

that I last saw her alive on Aug 6 1921.

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

Chr Bronchitis. (duration) 6 yrs. mos. ds.

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of -

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) M G Brueninger M.D.

8/8 1921 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: 8/10 1921

20 UNDERTAKER: Forrest & Cooper

ADDRESS: 406 Cumb St

N. B. [illegible] mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56019 ✓ D 56019

D 56019

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 S London Ave. ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry August Schleidt

(Residence in Baltimore: No. 13 S London Ave. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. April (Month) 28 (Day), 1863 (Year)

7-AGE. 58 yrs. 3 mos. 11 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Industrial Carrier
(b) General nature of industry, business, or establishment in which employed (or employer): Home Friendly Ins. Co.

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Jacob Schleidt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Woltmann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johanna Schleidt

(Address) 13 S London Ave.

15-

Filed ....., 191.... Registrar.

Robert P. Harrison,
Burial Permit Clerk.

AUG 10 1921

N. B.—Every item must be answered in every case. If any is unknown, say so. CAUSE OF DEATH in plain terms, so that it may be understood. All items important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. August (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 5 1921, to Aug 8 1921, that I saw him alive on Aug. 8 1921, and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Interstial Nephritis

(Duration) 4 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia Coma

(Duration) yrs. mos. 3 ds.

(Signed) Robt. P. Schleidt M. D.

Aug. 10, 1921. (Address) 1318 St. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cem

DATE OF BURIAL. Aug. 11, 1921.

20-UNDERTAKER W. Tickner Sons

ADDRESS North & Penna

D 56020 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 806 Pennington Ave. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Peter Lerp

(Residence in Baltimore: No. 806 Pennington Ave. Stg yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, August (Month) 30th (Day), 1893 (Year)

7-AGE, 27 yrs. 11 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cashier (Baltimore
(b) General nature of industry, business, or establishment in which employed (or employer): Car & Foundry Works

9-BIRTHPLACE, (State or Country): Curtis Bay A.A.Co.,Md.

PARENTS.

10-NAME OF FATHER: John Peter Lerp

11-BIRTHPLACE OF FATHER (State or Country): Baltimore, Md.

12-MAIDEN NAME OF MOTHER: Augusta Bierley

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Mignon Lerp

(Address) 806 Pennington Ave.

15-

Filed ....., 191.... Registrar.

Robert P. Harrison,
Burial Permit Clerk.

AUG 10 1921

N. B.—Every item of information should be carefully considered, that CAUSE OF DEATH may be properly classified. Data must be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August (Month) 8th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Pthisis Pulmon

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. C. Coates M. D. (Coroner.)

Aug 10 1921 (Address) 143 No Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Aug. 11th, 1921

20-UNDERTAKER: Joseph L. B. Cook — ADDRESS: 1003 W Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56021

CERTIFICATE OF DEATH.

43

D 56021

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 St. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Karneska

(a) RESIDENCE. NO. Unknown ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Factory-worker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed AUG 10 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5 1921

17 I HEREBY CERTIFY, That I attended deceased from August 4, 1921, to August 5, 1921, that I last saw her alive on August 5, 1921, and that death occurred, on the date stated above, at 2 P.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast
Metastases to lungs, liver etc.

(duration) 2 ? yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

8/6/1921 Address New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: AUG 6 1921

20 UNDERTAKER: Commissioner Health,

ADDRESS

[illegible] WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PRESCRIBED BLANKS must be filled EXACTLY. PRINCIPAL information should be carefully supplied. AGE should be stated EXACTLY. PRESCRIBED BLANKS must be filled EXACTLY. PRINCIPAL CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

28

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 56022

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

D 56022

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 S Broadway St.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME Lapshia Perez (Perez.)

(Residence in Baltimore: No. 712 S Broadway St.; ..... yrs., 5 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem.	White	Single

6-DATE OF BIRTH, March 26- (Month), (Day), 1921. (Year)

7-AGE, 0 yrs. 4 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant.

9-BIRTHPLACE, (State or Country), Baltimore, Md.,

PARENTS.

10-NAME OF FATHER, Joseph Perez,

11-BIRTHPLACE OF FATHER (State or Country), Spian,

12-MAIDEN NAME OF MOTHER Lillian Cridleand,

13-BIRTHPLACE OF MOTHER (State or Country), England,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lillian Perez, (Mother)

(Address) 712 So. Broadway

15- [illegible] KRAUTER

Filed AUG 10 1921 191.....

[illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 4th 1921, to Aug 10 1921, that I saw her alive on Aug 9 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Enteritis

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) John [illegible] M. D.

Aug. 10, 1921 (Address) 11 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cemetery

DATE OF BURIAL, August 11 1921.

20-UNDERTAKER M. F. Sadowski

ADDRESS # 705 So. Ann st

N. B.—Every item of information should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements important. See instructions on back of certificate.

Josephine Pawlowski.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56023

CERTIFICATE OF DEATH.

109

D 56023

(PLACE OF DEATH

CITY OF BALTIMORE (No. 1615 Shakespeare ST. W WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-FULL NAME Josephine Pawlowska

(Residence in Baltimore: No. 1615 Shakespeare St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Unknown —, 1872.
(Month) (Day) (Year)

7-AGE. 49 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Home wife.
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Poland.

PARENTS.

10-NAME OF FATHER. Stanislaus Zuchowski

11-BIRTHPLACE OF FATHER (State or Country). Poland.

12-MAIDEN NAME OF MOTHER Rosalia —

13-BIRTHPLACE OF MOTHER (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Pawlowski Husband

(Address) 1615 Shakespeare St.

15- Filed AUG 10 1921 ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 9, 1917.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Hernia

(Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Pleurisy

(Duration) — yrs. — mos. — ds.

(Signed) G. E. Weber M. D.
(Coroner)

Aug 9 1917 (Address) 1443 N. Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Stanislaus Cem.

DATE OF BURIAL. Aug 12, 1917.

20-UNDERTAKER M. F. Sadowski.

ADDRESS 705 S. Ann St.

N.B. Every item of information should be carefully answered. The CAUSE OF DEATH is given in plain terms, so that it may be properly classified. All questions are important. See instructions on back of certificate.

Spec.—6-9-13—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56024

D 56024

151

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carvelle Downey Duckette

(a) RESIDENCE. NO. Davidsonville, Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 9, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 17 hrs. 43 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Stockard Duckette

11 BIRTHPLACE OF FATHER (city or town) Davidsonville
(State or country) Md.

12 MAIDEN NAME OF MOTHER Edna Laura Duckette

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Mrs. Edna Laura Duckette
(Address) Davidsonville, Md

15 Filed AUG 10 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1921, to Aug 10, 1921, that I last saw him alive on Aug 10, 1921, and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows:

Prematurely

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) W. J. Colegrove, M. D.

, 19 (Address) Md. Gen. Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Davidsonville Md. DATE OF BURIAL 8/10/21 19

20 UNDERTAKER E B Starle ADDRESS 115 E West

Burial Permit Clerk

N. B.—WHOLE [illegible] should be carefully supplied. And [illegible] mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be [illegible] TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56025

D 56025

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 Union Ave 13 WARD)

2-FULL NAME Charles F. Carlin

(a) RESIDENCE NO. 1202 Union Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or mdn.
	1	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Arthur T Carlin

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Conley

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mary Carlin

(Address) 1202 Union Ave

15 Filed AUG 10 1921 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1921

17 I HEREBY CERTIFY That I attended deceased from July 31 1921 to Aug 9 1921

that I last saw him alive on Aug 9 1921 and that death occurred, on the date stated above, at 8.20 A.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C F Corbett M. D.

8-9. 1921 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden DATE OF BURIAL Aug 11 1921

20 UNDERTAKER Chenoweth Son Chestnut St ADDRESS

N. B.—WRITE PLAINLY, WITH INK. ALL ITEMS should be carefully supplied. AGE should be properly classified. EACH mation should be carefully supplied, so that it may be properly classified. EACH CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

17963 D 56026

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Weltman

(a) RESIDENCE NO. 60 Mairington Av. New Britain Conn. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 20 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Conn.

PARENTS

10 NAME OF FATHER Paul Weltman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden.

12 MAIDEN NAME OF MOTHER Elsa D Saltzandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

14 Informant (Address) Johns Hopkins Hospital Record

15 Filed AUG 10 1921 ROBERT J KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to Aug 9, 1921.

that I last saw h[illegible] alive on Aug 9, 1921.

and that death occurred, on the date stated above, at 12 M m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8/9/21

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Wm Darrach, M. D.

8-10-21, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Britain Conn. DATE OF BURIAL Aug 10 1921

20 UNDERTAKER J Ahrens ADDRESS 224 N Bway

N. B.—WRITE PLAINLY. Ages, dates and places must be stated. All items should be carefully supplied. Age should be given in years, months and days. Information should be carefully supplied. Age should be given in years, months and days. Information should be carefully supplied. Age should be given in years, months and days. Information

Heying

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56027

CERTIFICATE OF DEATH.

V 75-001

D 56027

1-PLACE OF DEATH: State Bath Hospital — REGISTERED No. C.

CITY OF BALTIMORE (No. Beech & Maple Ave. ST., in WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: August L. Heying.

(Residence in Baltimore: No. Beech, Near Mapleave. Overlea St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 16 (Day), 1871 (Year)

7-AGE, 30 yrs. 6 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Standard Oil Co.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Louis T. Heying

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine R. France

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Heying

(Address) Overlea Md.

15- AUG 10 1921

Filed ....., 191.... MARIE I. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an August (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said August (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto Accident

Fracture of Skull

(Duration) ..... yrs. ..... mos. 1 hr. ds.

CONTRIBUTORY (Secondary) Shock.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Blades M. D. (Coroner.)

Aug 14 1921 (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State Life yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Josephs Cemetary	Aug 12 1921
20-UNDERTAKER Fredk Lassahn & Sons	ADDRESS Fullerton Md.

N. B.—Every item of information should be carefully given, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Dates important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Glorioso

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56028

CERTIFICATE OF DEATH.

X 109 V D 56028

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., (WARD) 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Glorioso

(a) RESIDENCE. (No.) Lakeland, Md. ST., WARD. Lakeland Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Univ. Hosp. records
(Address)

15 Filed AUG 11 1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1921, to Aug 9, 1921, that I last saw her alive on Aug 9, 1921, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Surgical shock
(duration) yrs. mos. 1 hrs ds.

CONTRIBUTORY (Secondary) Perforated, strangulated Ventral hernia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Lakelane Md.

Did an operation precede death? yes Date of Aug 9, 1921

Was there an autopsy? no

What test confirmed diagnosis? Findings at operation

(Signed) R B Jones, M. D.

Aug 9 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	8/11 1921
20 UNDERTAKER J. J. Fahey & Sons	ADDRESS 1315 Light St

N. B.—Items should be carefully supplied, so that it may be properly mation should be carefully supplied, so that it may be properly CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56029

CERTIFICATE OF DEATH.

55-001

D 56029

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (NO. Monument St ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Rubin

(a) RESIDENCE. NO. 147 N. Montford Ave. ST., WARD.
(Usual place of abode)
(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — child
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Max Rubin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Klass

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Max Rubin
(Address) 147 N. Montford Ave.

15 Filed AUG 11 1921 16 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/6, 1921, to 8/10, 1921, that I last saw h[illegible] alive on 8/10, 1921, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis?

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr Zinberg, M. D.

8/10, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	8/11, 1921

20 UNDERTAKER Jack Davis 1411 E Balto St ADDRESS

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

D 56030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 79 ✓ D 56030

1-PLACE OF DEATH
CITY OF BALTIMORE (No. S. Fay. / Katherine & Reisterstown Rd. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Randolph

(Residence in Baltimore: No. 1519 Preston St. St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	married

6-DATE OF BIRTH, about November, 1873
(Month) (Day) (Year)

7-AGE. 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, Sidney Randolph

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Margaret Jones

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. H. Dennis

(Address) 130 Preston St.

15- ROBERT J. TAYLOR Burial Permit Clerk

Filed AUG 11 1921, 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic Heart disease

Dropsy days (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(Duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)

Aug 10, 1921 (Address) 2811 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
In the
At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL AUG 11 1921, 19

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Be sure to give CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56031 79 ✓ D 56031

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3808 Elm ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel T. McCullough

(a) RESIDENCE. NO. 3808 Elm ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J McCullough

6 DATE OF BIRTH (month, day, and year) March 12, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John B Hays Md.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Rosa Cole

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant (Address) Mrs. Howard Dandy 3508 Elm ave

15 Filed AUG 11 1921 [illegible] Registrar

Burial Permit Elect

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/8 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 8, 1921, that I last saw her alive on Aug 8, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Subjective Symptoms

(Signed) C. F Conglehil, M. D.

8-9, 1921 (Address) 3701 Roland Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middletown Cemetery DATE OF BURIAL: Aug 11, 1921

20 UNDERTAKER: E. Le Roy Stiffler ADDRESS: 125 E North Ave.

N. B.—Information should be carefully supplied, so that it may be properly transferred to certificates. CAUSE OF DEATH in plain terms, so that it may be properly transferred to certificates. See instructions on back of certificates. TION is very important.

D 56032 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56032

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1108 24th St.) (or) (WARD) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth J Tapscott

(Residence in Baltimore: No. 1108 24th St.) 60 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, Dec 31, 1833 (Month) (Day) (Year)

7-AGE 87 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Annapolis Md

PARENTS.

10-NAME OF FATHER Thomas J Marston

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Alice Marston

13-BIRTHPLACE OF MOTHER (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H A Edwards

(Address) 1108 24th St

15- Filed AUG 11 1921 ROBERT J BRUTEN Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 9, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY that I took charge of the remains described above, held an inquest (or authority or inquest) thereon and from the evidence obtained by autopsy (or inquest) find that said deceased came to ... death on the date stated above.
The CAUSE OF DEATH* was as follows:

Heart disease

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) John Heuisler M. D. (Coroner)

Aug 10 1921 Address 1792 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence ...

19-PLACE OF BURIAL, OR REMOVAL, Baltimore Cem't DATE OF BURIAL, Aug 12 1921

20-UNDERTAKER William Cook ADDRESS 502 E North Ave

N. B. Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Last birthday important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56033

CERTIFICATE OF DEATH.

28 D 56033

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 415 South Chapel ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma V. Killmayer

(a) RESIDENCE. No. 1106 N. Washington St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Killmayer

6 DATE OF BIRTH (month, day, and year) Nov 2-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bath Att

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lucian E. Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary E. Zumbrun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) John A. Killmayer 1106 N. Washington

15 Filed AUG 11 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 17th 1921, to Aug 8th 1921, that I last saw her alive on Aug 6th 1921, and that death occurred, on the date stated above, at 9.55 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Contact Tuberculosis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Heller M. D.

Aug 9th 1921 (Address) 1937 Gough St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Aug 12 1921
20 UNDERTAKER Wm Cain & Son	ADDRESS 502 E. North

N. B.—Items must be carefully supplied. Any information should be carefully supplied, so that it may be properly classified. Entire CAUSE OF DEATH in plain terms, so that it may be properly classified. Entire of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 D 56034

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 Mayfield Ave. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Dobler

(a) RESIDENCE. NO. 2224 Mayfield Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Dobler

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Chas. Seebold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Mary Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant John J. Dobler

(Address) 2224 Mayfield Ave.

15 Filed AUG 11 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 13th, 1921, to Aug 9th, 1921, that I last saw h alive on Aug 9th, 1921, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) 0 yrs. 0 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood-urine-Sputum & Eye ground exam.

(Signed) Gordon Antuss, M. D.

, 19 (Address) 42 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 8/11/21 19

20 UNDERTAKER Thos Kennedy Son

ADDRESS 1160 W Lexington

Notice should be carefully examined, so that it may be returned for correction if necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of informant is very important. See instructions on back of certificates.

Spec. — 6-9-19 — H. P. Co. — 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56035

D 56035

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE, No. St. Agnes Hospital ST.: 13 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mamie Liggett.

(a) RESIDENCE NO. 1028 E. North Ave ST.. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.
4 COLOR OR RACE: W.
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Liggett.

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE — Years: 48 yrs. — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER: Do not know
11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know
12 MAIDEN NAME OF MOTHER: Do not know
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant (Address): Albert Liggett 1028 E. North Ave.

15 Filed AUG 11 1921, 19 ROBERT B. KELLY Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-10 . 1921, to 8-10 . 1921, that I last saw h[illegible] alive on 8-10 . 1921, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:
Chr nephritis
(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Uraemia
(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of —
Was there an autopsy? no.
What test confirmed diagnosis? chemical

(Signed) Dudley P. Bruce, M. D.
, 19 (Address) ST. agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem
DATE OF BURIAL: 8/13/21 19

20 UNDERTAKER: Chas H. Cannard Son. ADDRESS 1811 W Mt Royal

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 560036 — 79 — D 560036

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2205 Callow Ave., ST. 13 WARD 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Tanzer,

(a) RESIDENCE. NO. 2205 Callow Ave., ST.. WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline A .Tanzer

6 DATE OF BIRTH (month, day, and year) Mch. 26th. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buyer for

(b) General nature of industry, business, or establishment in which employed (or employer) Deprt. Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Bohemia~~ Bohinia

PARENTS

10 NAME OF FATHER Ephriam Tanzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohinia

12 MAIDEN NAME OF MOTHER Josephine Steinbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohinia

14 Informant I. Tanzer (Address) 2205 Callow Ave

15 Filed AUG 11 1921 Docket & Chapter Burial Permit Class

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9th. 1921

17 I HEREBY CERTIFY, That I attended deceased from June. 10. 1920. to Aug. 9. 1921.

that I last saw him alive on Aug 8. 1921.

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Joseph William Kelly M.D.

. 19 (Address) 2327 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew, — DATE OF BURIAL: Aug. 11th 1921

20 UNDERTAKER David Sondheim — ADDRESS 118 W. Lt. Bo al

N. B.—[illegible] should be carefully supplied, so that it may be properly mation in plain terms, so that it may be CAUSE OF DEATH in plain terms. See instructions on back of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56037

CERTIFICATE OF DEATH.

40 D 56037

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3227 Abell Av ST.: 12th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia K. Rowley

(a) RESIDENCE. NO. 3227 Abell Av ST. 12 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 10 mos. 12 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 28, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	10	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk Sales Lady
(b) General nature of industry, business, or establishment in which employed (or employer) Laundry
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Edward K. Rowley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Amelia Kilsted

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Leslie A. Hart
(Address) 3227 Abell Ave

15 Filed AUG 11 1921 ROBERT I. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1921, to Aug. 9, 1921, that I last saw h[illegible] alive on Aug. 9, 1921, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Hemastemesis

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. A. Steenken, M. D.

, 19 (Address) 2949 Greenmount Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Olivet Aug 11 21

20 UNDERTAKER — ADDRESS

A. S. Marshall 3539 Fall Av

N. B.—[illegible] mation should be carefully supplied [illegible] CAUSE OF DEATH in plain terms, so that it may be properly [illegible] TION is very important. See instructions on back of certificates.

Spec. 6-9-13 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56038

D 56038

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Reamer

(a) RESIDENCE. No. 1820 Ruxton ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2 -	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Joseph Reamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Katie Rosenblatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records
(Address) Mercy Hospital

15 Filed AUG 11 1921 ROBERT J. KRAETER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 9, 1921, to Aug 11, 1921; that I last saw her alive on Aug 11, 1921; and that death occurred, on the date stated above, at 11:29 a. m.

The CAUSE OF DEATH* was as follows:

Premature Built

(duration) yrs. 7½ mos. ds.

CONTRIBUTORY (Secondary) Examination

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John F Emory, M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edwin Rosedale	8-11 1921
29 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Pratt

N. B.—[illegible] should be carefully supplied, so that it may be proper[illegible] mation should be carefully supplied, so that it may be properly entered. CAUSE OF DEATH in plain terms, so that it may be properly entered. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Paleher

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56039 — CERTIFICATE OF DEATH. — 152 — D 56039

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2211 E. Biddle St. 8 WARD)

2-FULL NAME Paul V. Paleher

(Residence in Baltimore: No. 2211 E. Biddle St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Baby

6-DATE OF BIRTH, Aug (Month) 10 (Day) 1921 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 6 hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby, (b) General nature of industry, business, or establishment in which employed (or employer): Md

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Frank Paleher

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Dard

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Paleher

(Address) 2211 E. Biddle St

15- Filed AUG 11 1921, 191.... ROBERT J. KRAUSE Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) J. J. Smith (Coroner.) M. D.

8-11, 1921 (Address) 4 E. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Aug 12, 1921

20-UNDERTAKER Frank Brockton — ADDRESS 906 Caldwell

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56040

CERTIFICATE OF DEATH.

7 4 D 56040

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Greene St (St.) 21 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Greek

(a) RESIDENCE. No. 723 St Peter St St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Anne E. Greek

6 DATE OF BIRTH (month, day, and year): Jan 23 1886

7 AGE — Years: 35 — Months: 6 — Days: 19 — If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teamster

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: James Greek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wife Frank Greek
(Address) 723 St Peter St.

15 Filed AUG 11 1921, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 7th, 1921, to Aug 9th, 1921, that I last saw him alive on Aug 9th, 1921, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Edema (Lungs)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene D. Harris M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Aug 12 1921.

20 UNDERTAKER: James Dignan & Son — ADDRESS: [illegible] S. Paca St

Burial Permit Clerk

N. B.—WRITE PLAINLY. All information should be carefully supplied. And that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56041

CERTIFICATE OF DEATH.

151 D 56041

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. St. Agnes Hospital ST.: 706 WARD)

2-FULL NAME. Mary Doris Smith.

(a) RESIDENCE. NO. 1809 Ramsay St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Infant 1920 Dec 18 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER M. A. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mrs. Wm. A. Smith

(Address) 1809 Ramsay St.

15 Filed AUG 11 1921 19 Registrar

BOMBERGER & KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1921

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1921, to Aug 10, 1921.

that I last saw h.. alive on Aug 10, 1921.

and that death occurred, on the date stated above, at 4 45 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Dudley P. Bowen, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug 11 1921

20 UNDERTAKER F. B. Hepperd ADDRESS 2236 Fed'l Ave

I. B.—Information should be carefully supplied. Remember that it may be properly changed CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

14999 7
D 56042

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. + 104

D 56042

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dale Foxwell

(a) RESIDENCE NO. Kirkman Somerset Co. Md WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. ~~7~~ mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		4	25	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin H. Foxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie R. Dashiell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) John Hopkins Hospital. Records Mt Vernon

15 Filed AUG 11 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 19-21

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 .19 21. to Aug 9 .19 21.

that I last saw her alive on Aug 9 .19 21.

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) M Dawson M. D.

8.10-21 .19 (Address) 144

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Somerset Co Md Mt Vernon — DATE OF BURIAL Aug. 11 1921

20 UNDERTAKER Wm C. Black ADDRESS 927 N. Broadway

CHARLES J. KRAUTER Burial Permit Clerk

N. B.—Whatever information should be carefully supplied and that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro-Intestinal Indigestion

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56043

CERTIFICATE OF DEATH.

104

D 56043

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3411 Foster Ave. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Thompson.

(a) RESIDENCE NO. 3411 Foster Ave ST., 76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or..... min.
		5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City.
(State or country)

PARENTS

10 NAME OF FATHER John Thompson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Greenfield

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country)

14 Informant John Thompson.
(Address) 3411 Foster Ave.

15 Filed AUG 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1921

17

I HEREBY CERTIFY, That I attended deceased from August 7, 1921, to August 8, 1921,

that I last saw h[e]r alive on August 8-1921, 19 21,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enterity

Acute Entero-Colitis

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) Infantile Sprue

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Thorough Exam.

(Signed) C. E. McClanahan, M. D.

Aug 11, 1921 (Address) 3508 Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Aug 12 19 21
20 UNDERTAKER Tally & Zeih	ADDRESS 403 S. Wa[illegible]

Burial Permit Clerk

mation should be carefully supplied, so that it may be proper
CAUSE OF DEATH in plain terms, so that it may be proper
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

149853
D 56044

HEALTH DEPARTMENT—CITY OF BALTIMORE

150 D 56044

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Moran

(a) RESIDENCE NO. 16 S. Edward Ave ST., WARD 1st
(Usual place of abode)
Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7-21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
		2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 200

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Tom Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Johns Hopkins Hospital
(Address) Ward 1

15 Filed AUG 11 1921 Burial Permit Issued Recorder

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1921, to Aug 9, 1921, that I last saw her alive on Aug 9, 1921, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus
Pneumococcic
Spina Bifida
Meningitis (duration) since birth. yrs. mos. ds.

CONTRIBUTORY (Secondary) None. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 8-9-21

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Jay McCain M. D.

8-9-21 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Bom DATE OF BURIAL 8/12 1921

20 UNDERTAKER J. J. Moran ADDRESS 300 E Balto St.

N. B.—Write plainly. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

D 56045

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56045

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. near 1st N. Mt Washington ST.: South Avenue WARD) 27

2-FULL NAME Rev. John L. Walsh

(Residence in Baltimore: No. South Avenue St.: 20 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
male	white	Married

6-DATE OF BIRTH: May (Month) 30 (Day), 1850 (Year)

7-AGE. 71 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clergyman
(b) General nature of industry, business, or establishment in which employed (or employer): R.C. 018

9-BIRTHPLACE, (State or Country), Frostburg Maryland

PARENTS.

10-NAME OF FATHER, Joseph Walsh

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary L Gaithis

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Evelyn L Walsh

(Address) Mt Washington

15- AUG 11 1921 Filed....., 191.... ROBERT J KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: August (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 29 1921, to Aug 10 1921, that I saw him alive on Aug 10 1921, and that death occurred, on the date stated above, at 7.10 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Left sided hemiplegia
(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(Duration) yrs. mos. 3 ds.

(Signed) William J Field M. D.

8.10...., 1921 (Address) Mt Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Aug 12, 1921

20-UNDERTAKER George J Smith — ADDRESS, Fayette St.

N. B.—Every item of information must be given in plain terms, so that it may be properly coded. CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15

D 56046

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1164 Battery. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Beveridge.

(a) RESIDENCE. NO. 1164 Battery ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 10 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George Beveridge.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ella Rhea.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) George Beveridge 1264 Battery Ave.

15 Filed AUG 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 — 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1921, to Aug 10, 1921, that I last saw him alive on Aug 10, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 7 mos. 16 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) N. Lee Bangley, M. D.

, 19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge.	Aug 11 1921

20 UNDERTAKER George J. Smith ADDRESS 900 W. Fayette St

mation should be given. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56047

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Zemaski

(a) RESIDENCE NO. 60 Smalley St. New Britain Conn. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male.	White	Single.

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 38 | Months | Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 08

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Johns Hopkins Hospital (Address)

15 Filed AUG 11 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9. 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1921, to Aug 9, 1921, that I last saw him alive on Aug 9, 1921, and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor (cerebellar) alveolar sarcoma which caused death three months

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) None. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? Yes Date of July 12, 21.

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological.

(Signed) H. R. Plath. M. D.

8/3, 1921 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Britain Conn. DATE OF BURIAL 8/11 1921

20 UNDERTAKER J. F. Fahey & Sons ADDRESS 318 Eight

N. B.—Whatever should be carefully supplied, so that it may be properly entered in the records. Information should be carefully supplied, so that it may be plain terms, so that it may be properly entered in the records. CAUSE OF DEATH in plain terms, so that it may be properly entered in the records. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56048

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. So Balto Hospital ST. 24 WARD) 184

REGISTERED NO. C 56048

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Rulka.

(Residence in Baltimore: No. 1332 Andrs. St.) 6m yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Child

6-DATE OF BIRTH, ... Aug. 15 ....., 1910
(Month) (Day) (Year)

7-AGE, ... 10 yrs. 11 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. Eugena Rulka

11-BIRTHPLACE OF FATHER (State or Country). Poorland

12-MAIDEN NAME OF MOTHER Mary Gjonskua

13-BIRTHPLACE OF MOTHER (State or Country). Poorland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Eugena Rulka

(Address)...1332 Andrus St.

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

AUG 11 1921

N.B.—Every item of information should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug. 9 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, au-
(Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Trauma. (abdomen)
Blows from cane.
(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Shock
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) G. E. Radis M. D.
(Coroner.)

Aug 11 1921 (Address) 1436 Gray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL. Holy Cross Brooklyn — DATE OF BURIAL. Aug 11 1921

20-UNDERTAKER Elmer W Conklin — ADDRESS 924 E Lafayette

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 56049

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56049

122

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 946 Harford Ave. WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas M. Coffey Sr.

(a) RESIDENCE. No. 946 Harford Ave. St.

(Usual place of abode) WARD.

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): April 15. 1865

7 AGE: Years 56 | Months 3 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman Sewer

(b) General nature of industry, business, or establishment in which employed (or employer): City Engineers Department

(c) Name of employer: Baltimore

9 BIRTHPLACE (city or town) (State or country): Patrick Colony Ireland

PARENTS

10 NAME OF FATHER: Patrick Coffey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Miss Kate Coffey 946 Harford Ave.

15 Filed AUG 11 1921, 19

Robert P. Harrison, Registrar

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18 1921, to Aug 9 1921, that I last saw h[illegible] alive on Aug 9 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pyonephrosis

Unknown (duration) at least yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Incontinence of Urine

Bladder trouble? (duration) Unknown 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Necropsis

What test confirmed diagnosis? Dr Bernard Wise

(Signed) Dr Bernard Wise, M. D.

8/10, 1921 (Address) 914 E Biddle St

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral DATE OF BURIAL: Aug 12

20 UNDERTAKER: Elmer W. Conklin ADDRESS: 2244 E Eag

malice should be printed in plain terms, so that it may be read by anyone. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

149413
D 56050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56050

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital St., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tony Consentino

(a) RESIDENCE NO. Pengies, Md. ST., WARD Pengies Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (~~HUSBAND of~~ (or) ~~WIFE of~~) Jos Consentino (Father)

6 DATE OF BIRTH (month, day, and year) Feb 9, 1915.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jos. Consentino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Vincenza Fugata

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Johns Hopkins Hospital (Address) Records

15 AUG 1 1921 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1921, to Aug 10, 1921,

that I last saw him alive on Aug 10, 1921,

and that death occurred, on the date stated above, at 11:50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine examination

(Signed) Cordano, M. D.

8-11-1921 (Address) 1917

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Lutheran Cemetery — DATE OF BURIAL Aug 12 1921

20 UNDERTAKER Todd Sassaman Sons — ADDRESS Fullerton

mation should be correct, complete and legible, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—4-9-19—H. P. Co.—1000 Bks.

D 56051

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56051

CERTIFICATE OF DEATH.

115

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 N.Fremont Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie R.Alcock,

(a) RESIDENCE NO. 622 N.Fremont Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept.4.1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Uniontown
(State or country) Carroll Co.Md.

PARENTS

10 NAME OF FATHER John D.Alcock,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Nate T.Meredith,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Sar St. Alcock
(Address) 622 N.Fremont Ave

15 Filed AUG 11 1921 Robert P. Harrison,
Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY. All information should be carefully supplied, so that it may be property ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug.10.1921

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1921, to Aug. 9th, 1921.

That I last saw her alive on Aug. 9th, 1921.

and that death occurred, on the date stated above, at 5.20 A.m.

The CAUSE OF DEATH* was as follows:

Hepatitis

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. B. Schwalka, M. D.

(Address) 822 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Uniontown. Carroll Co.Md	Aug 10 1921

20 UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson A

D 56052

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D 56052

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 208 N Arlington Ave ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Hobbs

(Residence in Baltimore: No. 208 N Arlington Ave St.; yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Male	Colored	Single

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE, 12 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER, Hobbs

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Nancy Hobbs

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A Brown

(Address) Norfolk Va

15-

Filed ..... 101.....

Robert F. Harrison, Registrar.

AUG 11 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 9, 1911 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Heart disease
probably Rheumatic

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Embolism & Coronary Sudden

artery (Duration) yrs. mos. ds.

(Signed) James M. Fenton M. D. (Coroner)

, 191... (Address) 700 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Norfolk Va	Aug 11 1911
20-UNDERTAKER	ADDRESS
Edwards Hendley & Biddle	

NB.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56053

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56053

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

2-FULL NAME Patrick E. Fitz Simmons

(a) RESIDENCE. NO. Mt Hope Retreat ST.: 28 WARD. New Haven - Conn.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. ds. How long in U. S., if of foreign birth? Since Birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single -

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) (2) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	60	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman. 018

(b) General nature of industry, business, or establishment in which employed (or employer) Religious Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mt Kenmare Ireland

PARENTS

10 NAME OF FATHER J. Fitzsimmons

11 BIRTHPLACE OF FATHER (city or town) Mt Kenmare (State or country) Ireland

12 MAIDEN NAME OF MOTHER C. Smythe

13 BIRTHPLACE OF MOTHER (city or town) Mt Kenmare (State or country) Ireland

14 Informant (Address) Records of Mt Hope Retreat Mount Hope Balto Md

15 Filed ..... 19 ..... Registrar

AUG 11 1921 Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 23rd 1920. to Aug 11th 1921.

that I last saw h[illegible] alive on Aug 11th 1921.

and that death occurred, on the date stated above, at 11. A. m.

The CAUSE OF DEATH* was as follows:

Paralysis - Chr. Left Hemiplegia

Post Cerebral Hemorrhage -

Abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia Paralytica -

Abt (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? New York City -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Aug 11. 1921 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Haven - Conn.	Aug-11/ 1921
20 UNDERTAKER STEWART & [illegible] COMPANY (Address) [illegible], Connecticut	ADDRESS [illegible] AVE.

N.B.—WHERE PHYSICIAN IS ATTENDING, information should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56054

D 56054

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Archer

(a) RESIDENCE. NO. 220 W. Fayette st. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phylis Archer

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement finisher

(b) General nature of industry, business, or establishment in which employed (or employer) 063

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Robert Archer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lizzie Craig

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D.C.

11 Informant Hospital Records (Address) M.T.H.

15 Filed AUG 11 1921, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1921, to Aug. 10, 1921, that I last saw him alive on Aug. 10, 1921, and that death occurred, on the date stated above, at 9.35a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Chas. Greene, M. D.

8-10-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury — DATE OF BURIAL Aug 11th 1921

20 UNDERTAKER Wm J. Jackson — ADDRESS 106 East St

Information should be carefully supplied, so that it may be properly entered on the CAUSE OF DEATH in plain terms, so that it may be properly entered on the back of certificates. See instructions on back TION is very important.

D 56055 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56055

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Md. General Hosp. REGISTERED No. C 1754-004

CITY OF BALTIMORE (No. ~~2119 Linden Ave~~ ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Huchberger

(Residence in Baltimore: No. 2119 Linden Ave St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
female	white	widow

6-DATE OF BIRTH. Oct. 16, 1839 (Month) (Day) (Year)

7-AGE. 82 yrs. 9 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Joel Wolfe Elmer

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Theresa Brown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Huchberger

(Address) 2119 Linden Ave

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.

AUG 11 1921
Special Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 11, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following
Street Car accident

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Heneman M. D. (Coroner.)

Aug 11, 1921 (Address) 702 Eutaw Bldg

*(State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Linden near Duncan

Former or usual residence. 2119 Linden Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Hebrew	Aug 12, 1921
20-UNDERTAKER J. Ahrens & Co	ADDRESS 1611 Mad ave

B.—Every item of information should be carefully given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56056 D 56056

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 Spalding Ave ST.; 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Brown Sheare

(Residence in Baltimore: No. 203 Spalding Ave St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, May 17, 1841
(Month) (Day) (Year)

7-AGE, 80 yrs. 2 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, Macia Sheare

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Sheare

(Address) 203 Spalding Ave

15-

Filed AUG 11 1927, 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

N.B.—Every item of information called for in this certificate is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 9th, 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20 1927, to Aug 9th 1927, that I saw h.im alive on Aug 9th 1927, and that death occurred, on the date stated above, at 5:50 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

(Signed) J. B. Cauthorn M. D.

8/10, 1927. (Address) 1901 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Aug 13, 1927.

20-UNDERTAKER Lilly & Gile ADDRESS 402 S. Wolfe St.

(Mills)

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 56057 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56057

CERTIFICATE OF DEATH. 37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mount Hope Retreat ST.: 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. S. Miles

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28th WARD. Relay Balto Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 28 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Miles-

6 DATE OF BIRTH (month, day, and year) Oct 11-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Conductor.

(b) General nature of industry, business, or establishment in which employed (or employer) Car Work. 078

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Mills

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Kate Mills

13 BIRTHPLACE OF MOTHER (city or town) Charles Co (State or country) Md

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md Balto Md

15 Filed AUG 11 1921, 19... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14 . 1921 . to Aug. 10th . 1921 . that I last saw him alive on Aug 10th . 1921 . and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Paresis. Gen. Luetic -

abt (duration) 1 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Pardee Mania.

abt (duration) 1 yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? W. Test -

(Signed) Frank J Flannery . M. D

Aug 10. 1921 (Address) Mt Hope Md -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge Md	Aug 12 1921
20 UNDERTAKER Wm J Kirkner & Sons	ADDRESS Norfolk & Pa

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56058

CERTIFICATE OF DEATH.

135 D 56058

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1308 Largent — ST.; 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Buechel —

(a) RESIDENCE. No. 1308 Largent — ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — William Buechel

6 DATE OF BIRTH (month, day, and year) Augs-tt 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
38			1 —	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Wentworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr Wm Buechel

(Address) 1308 Largent St —

15 Filed AUG 11 1921, 19

Robert F. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/10/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/4/ 1921, to 8/10/ 1921,

that I last saw h[illegible] alive on 8/10/ 1921,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage during + after pulmonation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Bernard J Finn, M. D.

8/11/ 1921 (Address) 910 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 13 1921
20 UNDERTAKER	ADDRESS
John Thomas Ford	901 Hollins St

I.—WRITE [illegible] mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 56059

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56059

61

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West End Maternity.

CITY OF BALTIMORE: (No. 112 N. Calhoun St. ST., 19 WARD)

2-FULL NAME Beatrice Louise Fehner.

(a) RESIDENCE NO. 2636 Meanple Lane ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 4, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ddd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Maximillian Fehner.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Lillian Jackson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Anne Rundle County

14 Informant Louis M. Timko
(Address) Funeral Director

15 Filed ..... 19 ..... Registrar

AUG 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1921, to Aug. 11, 1921.; that I last saw h[illegible] alive on Aug. 11, 1921., and that death occurred, on the date stated above, at 3.15 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cerebral Meningitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Louis M. Timko, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jackson Grove Severn Md

DATE OF BURIAL Aug 12 19 21

20 UNDERTAKER Wm Cook & Son E Balto

ADDRESS

N. B.—WRITE plainly. Every question should be carefully answered, so that it may be properly coded. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly coded. CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

State—6-9-1)—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56060

D 56060

CERTIFICATE OF DEATH.

78

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 315 Spaulding Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Leland Warner

(a) RESIDENCE. NO. 315 Spaulding Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 19th 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	3	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School boy
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sherwood Maryland

PARENTS

10 NAME OF FATHER James Leland Warner

11 BIRTHPLACE OF FATHER (city or town) Sherwood (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ethel B Howeth

13 BIRTHPLACE OF MOTHER (city or town) Sherwood (State or country) Maryland

14 Informant Mr. James H Warner
(Address) 315 Spaulding Ave

15 Registered AUG 11 1921 19 Registrar Robert P. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1921, to Aug 11th, 1921, that I last saw him alive on Aug 11th, 1921, and that death occurred, on the date stated above, at 12:50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Malignant Endocarditis
(Heart Disease, Various)

(duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) Wash Ed Yeungner M. D.

, 19 (Address) 1013 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge DATE OF BURIAL: Aug 13 24

UNDERTAKER: Wm Cade & Son ADDRESS: 1826 E North Ave

Stamped: AUG 11 1921

Be property [illegible] certificates.

mation should be carefully supplied, so that it may be
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of cer

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56061

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 N Brice ST.: 16 WARD)

2-FULL NAME Bertha L Cline

(a) RESIDENCE. NO. 601 N Brice ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 6 1902

7 AGE: Years 19 Months 3 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sales Lady

(b) General nature of industry, business, or establishment in which employed (or employer): Woolworth Co

(c) Name of employer: Baltimore Md

9 BIRTHPLACE (city or town) (State or country): John E Cline

PARENTS

10 NAME OF FATHER: Baltimore Md

11 BIRTHPLACE OF FATHER (city or town) (State or country): Elizabeth Zimmerman

12 MAIDEN NAME OF MOTHER: Baltimore Md

13 BIRTHPLACE OF MOTHER (city or town) (State or country): John E Cline

11 Informant (Address): 611 N Brice St

15 Filed AUG 11 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 28 1921, to Aug 11 A. 1921, that I last saw h alive on Aug 10 A. 1921, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary): Hodgkins

(duration) yrs. One mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj Owen Cleary M. D.

11, 1921 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem DATE OF BURIAL: Aug 12 1921

20 UNDERTAKER: William Cadwallader ADDRESS

N. B.—WRITE PLAINLY. WITH UNFADING INK. All items should be stated. EXACTLY. AGE should be given. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56062

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3401 Morris ave ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Col Geo W F Vernon

(a) RESIDENCE. No. 3401 Morris ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Todd Vernon

6 DATE OF BIRTH (month, day, and year) June 14 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate and Claim Agent

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Maryland

PARENTS

10 NAME OF FATHER Nathaniel Vernon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Charlotte Donne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant (Address) Anna D Vernon 3401 Morris ave

15 Filed AUG 11 1921, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/11/21 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 5th, 1921, to Aug 11th, 1921, that I last saw him alive on Aug 7th, 1921, and that death occurred, on the date stated above, at 11:20 a m.

The CAUSE OF DEATH* was as follows:

Sudden Brain hemorrhage

Contributory Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Renal disease, Senile heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diognosis? None made, very sudden

(Signed) Geo. H. Boerner, M. D.

, 19 (Address) 2102 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Olivet Cemetery Frederick Md.

DATE OF BURIAL Aug 13 1921

20 UNDERTAKER Chas. S. Black

ADDRESS 742 W. North Ave

G. B.—WRITE PLAINLY. All questions should be carefully answered. AGE should be carefully supplied. Any information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LOCATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56063

CERTIFICATE OF DEATH.

91 D 56063

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 434 Worthington St., ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Jones

(a) RESIDENCE. No. 434 Worthington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) March 2, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) born in Balt City

PARENTS

10 NAME OF FATHER David Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) born in Balt-

12 MAIDEN NAME OF MOTHER Elzleth Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) born in Md

14 Informant Elzleth Jones
(Address) 434 Warmsley St

15 Filed AUG 12 1921 Robert J. Cluten Registrar
Burial Permit Clerk

N. B.—WRITE PLAINLY. All items should be properly classified. Any information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly classified. Extra information on back of certificates. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 1921, to Aug 10, 1921, that I last saw h. alive on Aug 10, 1921, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

x

x

(duration) 1 yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Hx of cold and chest

x (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) Geo Dall M. D.

, 19 (Address) 426 E 20 St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 12 1921
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	1735 Aisquith

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56064

CERTIFICATE OF DEATH.

28 D 56064

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 Edward ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma Camper

(a) RESIDENCE. NO. 1229 Edward ST., 5 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. A. Camper

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) born in Baltimore

PARENTS

10 NAME OF FATHER John Haines

11 BIRTHPLACE OF FATHER (city or town) And

(State or country)

12 MAIDEN NAME OF MOTHER Ann Gilliage

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) And

14 Informant Geo. A. Camper

(Address) 1229 Edward St.

15 Filed AUG 12 1921 [illegible] Registrar

Burial Permit Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9. 1921.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921. to Aug. 8. 1921.

that I last saw h[illegible] alive on Aug. 8. 1921.

and that death occurred, on the date stated above, at 10-10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. of Sputum

(Signed) Robert J. Green, M. D.

8-10. 1924 (Address) 120½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Glion Cem	Aug 13 1924
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56065

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56065

CERTIFICATE OF DEATH.

20

REGISTERED NO.....

1-PLACE OF DEATH South Baltimore Hospital

CITY OF BALTIMORE: (No. 1213 Light ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Briscoe, Jr.

(a) RESIDENCE. NO. 5221 York Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Sophia H. Briscoe

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisville Ky

PARENTS

10 NAME OF FATHER James Briscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Huppman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Arthur F. Lee Briscoe
(Address) Glenwood Apartments

15 Filed [illegible] 19 [illegible] Registrar

AUG 12 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1921, to Aug. 10, 1921, that I last saw him alive on Aug 10, 1921, and that death occurred, on the date stated above, at 2:25 P m.

The CAUSE OF DEATH* was as follows:

Septicemia by streptococcus viridens

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelitis (bilateral) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? At his residence

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Culture

(Signed) A. F. Rees, M. D.

Aug 15, 1921 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Aug 12 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56066

CERTIFICATE OF DEATH.

1042

D 56066

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1518 Clifton St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles D. Fordrick

(Residence in Baltimore: No. 1508 Clifton St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 9, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. 2 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Charles F. Fracht

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Catherine L. Darnell

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles F. Fracht

(Address) 508 Clifton Ave

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Rickets;

(Duration) ..... yrs. 4 mos. 1 ds.

CONTRIBUTORY (Secondary) Inanition

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) E. W. Wales M. D.
(Coroner.)

Aug 11 1921 (Address) 143 N. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Aug 13, 1921

20-UNDERTAKER Wm Cook

ADDRESS 502 E North

N. B.—Every item of information must be given, so that it may be properly entered in the records. In CAUSE OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 1 D 56067

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1927 McHenry ST. 19 WARD)

2-FULL NAME John E Shanahan

(a) RESIDENCE. NO. 1927 McHenry ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 21. 21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Frank M Shanahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Margaret Reis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant T. M. Shanahan
(Address) 1927 McHenry St

15 Filed AUG 12 1921 [illegible] Registrar

Burial Permit Issued [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1921, to Aug 11, 1921, that I last saw him alive on Aug 11, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions.

(duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro-Enteritis

Duplicate

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones M. D.

Aug. 19 (Address) Emmitsburg Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Aug 13 1921

20 UNDERTAKER John J Fields ADDRESS 1200 N Fountain st

REGISTRATION DISTRICT NO. [illegible]

CAUSE OF DEATH in plain terms, so that it may be understood by persons not physicians. See instructions on back of certificates.
TION is very important.

Spec.—6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56068

CERTIFICATE OF DEATH.

5 50 D 56068

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 514 N. Central Ave ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Griffith

(a) RESIDENCE. NO. 514 N. Central Ave ST.

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Griffin

6 DATE OF BIRTH (month, day, and year) June 8, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	~~11~~ 2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic General 203

(b) General nature of Industry, business, or establishment in which employed (or employer) Private work at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Daniel J. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Jane Shiver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Ida Nicholson (sister) (Address) 174 Jefferson St.

15 Filed AUG 12 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5, 1921, to Aug. 9, 1921, that I last saw h.... alive on Aug. 8, 1921, and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary

(Signed) Ralph Young, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 12 1921

20 UNDERTAKER Chas. H. Jenkins ADDRESS 446 N. Carolina St.

mation should be given in plain terms, so that it may be clearly understood. CAUSE OF DEATH in plain terms, so that it may be clearly understood. CAUSE OF DEATH TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56069

D 56069

CERTIFICATE OF DEATH.

REGISTERED NO. 1702

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1000 Light St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. M. Myers

(a) RESIDENCE. NO. 1000 Light St. ST. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman E. Myers

6 DATE OF BIRTH (month, day, and year) Setl 24 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Boercherding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz. Bartenfelder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Herman E. Myers 1000 Light St.

15 Filed AUG 12 1921 ROBERT B KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1921, to Aug 10, 1921, that I last saw h er alive on Aug 10, 1921, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) about 2 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? phys

(Signed) Wm E Stifler, M. D.

8/11, 1921 (Address) 1319 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: 8/13 1921

20 UNDERTAKER: Fleo McCully

ADDRESS: 130 E. Fort

037

IMPORTANT—Fill out all items in plain terms, so that it may be possible to code the CAUSE OF DEATH correctly. Do not use abbreviations. See instructions on back of certificates. TION is very important.

Spec. — 6-9-19 — H. P. Co. — 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 56070

D 56070

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST.: No WARD)

2-FULL NAME Emma Heine

(a) RESIDENCE. NO. Bay View Asylum ST., WARD. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

070

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry Heine

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant: Hospital Records (Address) M.T.H.

15 Filed AUG 12 1921 [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1919, to Aug. 10, 1921, that I last saw her alive on Aug. 10, 1921, and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? B.B. in sputum, X-ray.

(Signed) Clyde Mitchell M. D.

8-11-21, 1919 (Address) Municipal Tuberculosis Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 12 1921
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be classified. Many diseases are peculiar to infancy and old age, and many are contagious. Violent deaths require special inquiry. See back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56071

CERTIFICATE OF DEATH.

91 D 56071

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 430 Elsinore ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Rohlfing

(a) RESIDENCE. No. 430 Elsinore ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Saloma Rohlfing

6 DATE OF BIRTH (month, day, and year) Jan 5, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housepainter Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Christian Rohlfing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Saloma Rohlfing
(Address) 430 Elsinore ave

15 Filed AUG 12 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1921, to Aug 10, 1921, that I last saw h. alive on Aug 10, 1921, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Senile degeneration

(duration) 1 yr. 6 mos. — ds.

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) — yrs. — mos. 7 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. F. Robinson, M. D.

. 19 (Address) 712 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. County	Aug 13 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1134 Eager

mation should be given in plain terms, so that it may be understood by the general public. CAUSE OF DEATH in plain terms, so that it may be understood by the general public. CAUSE OF DEATH in plain terms, so that it may be understood by the general public. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56072

CERTIFICATE OF DEATH.

34 D 56072

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 S Highland Ave. WARD) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Esther M. Gerding

(Residence in Baltimore: No. 305 S Highland Av St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 22, 1901
(Month) (Day) (Year)

7-AGE, 20 yrs. 4 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Jacob E Gerding

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Rosa Norr

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob E. Gerding

(Address) 305 Highland Ave

15- Filed AUG 12 1921, 191.... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 7 1921 to Aug 10 1921, that I saw her alive on Aug 10 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Fallopian Tube

(Duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. H. Cushman M. D.

Aug 11, 1921. (Address) 3100 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oaklawn — DATE OF BURIAL, Aug 13, 1921

20-UNDERTAKER Fickle & Fickle — ADDRESS 1739 Eager

CAUSE OF DEATH to be plainly written. Every question must be answered if important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56073

CERTIFICATE OF DEATH.

81 D 56073

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 W. Lanvale ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur A. Clendenin.

(a) RESIDENCE. NO. 1210 W. Lanvale ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced (write the word)~~: Married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Wilhelmina L. Clendenin

6 DATE OF BIRTH (month, day, and year): Jan 16 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Williams & Wilkens Co Balto Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Arthur A Clendenin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Susan Ricketts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Wilhelmina L Clendenin 1210 W. Lanvale St.

15 Filed AUG 12 1921 19 ROBERT I. FRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1921, to Aug 10 1921.

That I last saw h-- alive on Aug 9 1921.

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Linthicum, M. D.

Aug 12 1921 (Address) 826 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Aug 15 1921
20 UNDERTAKER: Partsch & Goetz	ADDRESS: 172 W. Lanvale St.

CAUSE OF DEATH in plain terms, so that it may be classified. Do not use abbreviations or initials. Do not report symptoms, but the disease causing death. Do not report conditions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—4-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56074

CERTIFICATE OF DEATH.

150 D 56074

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1100 W. Mulberry ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Johnson Gantz

(a) RESIDENCE. No. 1100 W. Mulberry ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos. 1 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) August 10/21

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John C. Gantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ada Gebhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) John C. Gantz 1100 W Mulberry St

15 Filed AUG 12 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 11 1921

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1921, to August 11, 1921, that I last saw him alive on August 11, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) ✓ yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) M. A. O'Neill, M. D.

8/12, 1921 (Address) 108 N. Bolton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls Violetville — DATE OF BURIAL: 8-13 1921

20 UNDERTAKER: Mrs. Chas A. G. Rohde — ADDRESS: 600 N Arlington Ave.

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. See back of certificates.
TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56075

CERTIFICATE OF DEATH.

104 D 56075

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hagan

(a) RESIDENCE. No. Childs Hoff Nursery ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant
(Address)

15 [illegible] AUG 12 1927 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/10 1927

17 I HEREBY CERTIFY, That I attended deceased from 8/9 . 1927 . to 8/10 . 1927.

that I last saw h[illegible] alive on 8/10 . 1927.

and that death occurred, on the date stated abnve, at 12 30 P m.

The CAUSE OF DEATH* was as follnws:

Marasmus

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease cnntracted if not at place of death?

Did an nperation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Zozinberg, M. D.

8/12 1927 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

AUG 1 1927

CAUSE OF DEATH in plain terms, so that it may be understood by the laity. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Ileocolitis

Form —6-9-19—H. P. Co.—1000 Bks.

D 56076

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56076

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Foreman

(a) RESIDENCE. No. 708 Pennsylvania Ave. ST.: ..... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James C Foreman

6 DATE OF BIRTH (month, day, and year) Apr. 29-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Solomon Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Mapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant James C. Foreman
(Address) 708 Pennsylvania Ave

15 AUG 12 1921 BOARD OF HEALTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1921, to Aug 10, 1921, that I last saw her alive on Aug 10, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Surgical Shock and Pneumonia

(duration) ... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 5 1921

Was there an autopsy? Released during illness

What test confirmed diagnosis? Signs & Symptoms

(Signed) John J. Brown M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 13 1921
20 UNDERTAKER Jno. M. Johnson	ADDRESS 1234 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be understood by the general public. See reverse side for certificates. THIS is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56077 CERTIFICATE OF DEATH. 1920 D 56077

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 4 ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alex Hodgdon

(a) RESIDENCE. NO. 105 N. Gay St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11m yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of 1856

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Alex Hodgdon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Louise Ovei

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed AUG 12 1921 ROBERT J. BRUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8 1921

17 I HEREBY CERTIFY, That I attended deceased from August 3 1921 to August 8 1921, that I last saw h im alive on August 8 1921, and that death occurred, on the date stated above, at 11:25 A. m.

The CAUSE OF DEATH* was as follows: Chronic diffuse nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

, 19 (Address) City Hosp. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL: 19

20 UNDERTAKER ADDRESS AUG 1921

Commissioner Health.

CAUSE OF DEATH in plain terms, so that it may be understood by the laity. Use no abbreviations or ditto marks. Be specific and give the name of the disease causing death, not merely a symptom or mode of dying, such as heart failure, asthenia, etc. If from violence, state the means and nature of injury, and whether accidental, suicidal or homicidal. In deaths of women, always state whether the deceased was pregnant or had been pregnant within three months prior to death. In deaths from any of the diseases designated by an asterisk, it is very important that a complete statement of the case be made. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56078

D 56078

CERTIFICATE OF DEATH.

4 X 79

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pratt & West Fallsdale ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John. Rice

(Residence in Baltimore: No. Pratt & West Fallsdale. St.; yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single.

6-DATE OF BIRTH, ... (Month) ..... (Day) 1851. (Year)

7-AGE, 70 yrs. ..... mos. ..... ds.	If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country) Baltimore England

PARENTS.

10-NAME OF FATHER. Not known.

11-BIRTHPLACE OF FATHER (State or Country). Not known.

12-MAIDEN NAME OF MOTHER Not known.

13-BIRTHPLACE OF MOTHER (State or Country). Not known.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Delp

(Address) Pratt & West Fallsdale

15- AUG 12 1921 ROBERT I KRAUTER Filed ....., 191.... Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 8 21, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Duration Unknown

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner) ..... M. D.

Aug 12 1921 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Crisfield Md.

19-PLACE OF BURIAL OR REMOVAL, Lynchy Cem. DATE OF BURIAL, 7-1, 1921.

20-UNDERTAKER H. Freeman ADDRESS 32 S Broadway

N. B.—Every item of information should be properly classified. Do not omit any item. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D 56079

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D 56079

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3142 Elliott ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melba M. Waudby.

(Residence in Baltimore: No. 3142 Elliott St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	single

6-DATE OF BIRTH, April (Month) 9th (Day), 1921 (Year)

7-AGE, ...yrs. 4 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, William K. Waudby

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Alberta M. Hawes

13-BIRTHPLACE OF MOTHER (State or Country), Phila. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William K. Waudby

(Address) 3142 E. Elliott St.

15- Filed AUG 12 1921, 191... ROBERT J. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 11 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Medical Ex. find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thomas J. Kinnamon M. D. (Coroner.)

8/12 1921 (Address) 1802 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem. DATE OF BURIAL, Aug. 13 1921

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

N.B.—Every item of information should be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56080

CERTIFICATE OF DEATH.

104 D 56080

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 18 N. Eliston. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Remlein

(a) RESIDENCE. NO. 18 N. Eliston ST., 6 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Sebastian Remlein

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Fannie M Mauder

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Sebastian Remlein
(Address) 18 N Eliston St.

15 Filed AUG 12 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1921, to Aug 11, 1921, that I last saw h— alive on Aug 11, 1921, and that death occurred, on the date stated above, at 10 50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ileo Colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John G Owen, M. D.

Aug 12 1921 (Address) 35 N Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Aug 13 1921

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

Mail to State Board of Health, Baltimore, Md., for registration. CAUSE OF DEATH in plain terms, so that it may be understood by the laity. See back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56081

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1827 Jackson ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Brannon

(a) RESIDENCE. NO. 1827 Jackson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Lawrence Brannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bessy Heller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. Hinkley
(Address) 1827 Pennington

15 Filed AUG 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9. 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 30, 1921, to Aug. 9, 1921, that I last saw him alive on Aug 9, 1921, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus of Years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. T. Seabury, M. D.

8/11. 1921 (Address) 408 Fort.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	8/13 1921
20 UNDERTAKER	ADDRESS
J. Slingsbaus	2124 Pink

CAUSE OF DEATH in plain terms, so that it may be classified. See back of certificates.
TION is very important. See instructions on back.

D 56082

(Frank)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56082

CERTIFICATE OF DEATH.

REGISTERED No. C 172

(PLACE OF DEATH

CITY OF BALTIMORE (No. 1e Balto Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fr L. Lantess.

(Residence in Baltimore: No. 3227 Paca St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1880.
(Month) (Day) (Year)

7-AGE, 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Iron moulder
(b) General nature of industry, business, or establishment in which employed (or employer)..... 079

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lantess

(Address) 3227 Paca St

15-

Filed ..... Robert, Bpl. Harrison, Registrar.
(Burial Permit Clerk.)

DEC 12 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., 19 21
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or (inquiry.) found that said deceased came to h death on the day stated above.

The CAUSE OF DEATH was as follows:

Acu Dilatation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxia (Chloroform)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Blades M. D.
(Coroner)

(Address) 1143 N. Broadway

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ... 12 1921
20-UNDERTAKER Wm Dalrymple	ADDRESS 01 N Eutaw St

N.B.—Every item of information should be given if possible, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information should be given if possible, so that it may be properly classified. important. See instructions on back of certificate.

fractured skull + ribs died at South Ballo General Hospital

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

D 56083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56083

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3134 Parrish ST. 19 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanch Wright

(Residence in Baltimore: No. 3134 Parrish St. 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	married

6-DATE OF BIRTH, ..., 1904
(Month) (Day) (Year)

7-AGE, 17 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): 137

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Thomas Sellers

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Kate Tabb

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Levi Tabb

(Address) 230 N Bruce St

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk,
Registrar.

AUG 12 1921

NB.—Every item of information should be carefully supplied. Each statement in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug 10 ....., 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H Fenton M. D.
(Coroner.)

Aug 12, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Aug 13, 1921
20-UNDERTAKER	ADDRESS
Boston & Tennant	1140 N Lakewood st

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56084

D 56084

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Magill

(a) RESIDENCE. NO. 2502 E. Hoffman ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Magill.

6 DATE OF BIRTH (month, day, and year) Sept. 12, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

017

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John. McGill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Rebecca Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Millen McGill (Address) 1802 N. Shutter

15 Robert F. Harrison, Registrar

Burial Permit Clerk.

12 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12 1921

17

I HEREBY CERTIFY, That I attended deceased from August 8, 1921, to August 12, 1921, that I last saw him alive on August 12, 1921, and that death occurred, on the date stated above, at 6.10 a. m.

The CAUSE OF DEATH* was as follows:

General arteris Sclerosis

Rupture of Cerebral Vessel.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secundary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. M. Timsko, M. D.

(Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Aug 19
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E. North

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

D 56085

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 D 56085

REGISTERED No. C .....

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No 3925 Frisby St.: 9 WARD)

2 FULL NAME Serena L. Smith

(Residence in Baltimore: No. 3925 Frisby St. St.: 89 yrs. 11 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Sept 6, 1831 (Month) (Day) (Year)

7 AGE: 89 yrs. 11 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Purnell F. Smith

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Everet

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) May S. Hall

(Address) 665 Park Ave

15 Robert P. Harrison,
Filed 191
Burial Permit Clerk. REGISTRAR

AUG 12 1921

N. B.-Every item of information should be carefully supplied. AGE must be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 11 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19, 1921, to Aug 11 1921, that I saw h.. alive on Aug 11, 1921, and that death occurred, on the date stated above, at 9.30 P. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. G. Prentiss M. D.

Aug 12, 1921 (Address) 634 Cathedral Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Kennedy Ville Kent Co Md — DATE OF BURIAL: Aug 13. 1921

20 UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Greenmt Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 56086 HEALTH DEPARTMENT—CITY OF BALTIMORE (James) D 56086

CERTIFICATE OF DEATH. 81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 S. Washington ST.; V WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catharine Jarmus

(Residence in Baltimore: No. 522 S. Washington St.; 50 yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH, April 27, 1836 (Month) (Day) (Year)

7-AGE, 85 yrs. 2 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Bichman Germany

PARENTS.

10-NAME OF FATHER, — Jarson

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Jarmus

(Address) 515 N. Decker Ave.

15-

Filed ....., 191.....

Robert P. Harrison,

Burial Permit Clerk. Registrar.

AUG 12 1921

CAUSE OF DEATH in plain terms, if important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 11th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1921, to Aug 11 - 1921, that I saw h e alive on Aug 8 - 1921, and that death occurred, on the date stated above, at 12 00 A m.

The CAUSE OF DEATH* was as follows:

Arteria sclerosis

Not Known (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) age

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. J. Keller M. D.

Aug 11, 1921 (Address) 222 W. Monument St.

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Aug. 15, 1921
20-UNDERTAKER	**ADDRESS**
H. Dandes & Sons	1710 Eutaw St.

Spec.—1-10-21—M&T—1500 Blks.

D 56087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56087

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3111 Fleet ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Henderson

(a) RESIDENCE NO. 3111 Fleet ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. Henderson

6 DATE OF BIRTH (month, day, and year) Jan. 24, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Caleb D. Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Alice Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Charles L. Henderson 3111 Fleet St

15 Filed AUG 12 1921, 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1921, to Aug 10, 1921, that I last saw him alive on Aug 9, 1921, and that death occurred, on the date stated above, at 10:05 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocarditis acute

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Harvey B. Stillon, M. D.

8/11, 1921 (Address) 315 S Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Aug 13 1921

20 UNDERTAKER: H. Sanders & Sons — ADDRESS: 710 Fleet St

mation should be carefully supplied, so that it may be properly
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56088

CERTIFICATE OF DEATH.

120

D 56088

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 761 W. Cross ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses T. Deaver

(a) RESIDENCE. NO. 761 W Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Deaver

6 DATE OF BIRTH (month, day, and year) Feb 29 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Stephen Deaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Sarah Harvey (Address) 761 W Cross St

15 Filed . 19 Robert F. Harrison Registrar

G 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to August 14, 1921, that I last saw him alive on April 11, 1921, and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interst Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of Foot

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen D Davis, M. D.

, 19 (Address) 1129 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Aug 13 1921
20 UNDERTAKER	ADDRESS
James Digman & Son	1000 S. Paca St

mation should be given in answering the following questions. Use the space for remarks to make the meaning clear. Do not abbreviate. Write the CAUSE OF DEATH in plain terms, so that it may be properly understood. Do not use terms of occupation, but specify the trade or profession. Do not use the word "Laborer." Be sure to answer every question. Your certificate may be returned if incomplete. TION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56089

CERTIFICATE OF DEATH.

63 D 56089

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Dibbons Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Richard Turner

(a) RESIDENCE NO. 2 Dibbons Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Turner

6 DATE OF BIRTH (month, day, and year) March 4, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Retired

9 BIRTHPLACE (city or town) Phila

(State or country) Pa

PARENTS

10 NAME OF FATHER John Turner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Emma Lambert

13 BIRTHPLACE OF MOTHER (city or town) Pa

(State or country)

14 Informant Mrs. Geo Battee

(Address) 2 Dibbons Ave

15 Robert P. Harrison, Registrar

AUG 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1921. to Aug 10, 1921.

that I last saw h[illegible] alive on Aug 9, 1921.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxaemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio sclerosis + Multiple Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

Aug 10 1921 (Address) 4706 Harford Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 13 21
20 UNDERTAKER	ADDRESS
Wm Tickner Sons	Balto Md

mation should be carefully supplied, so that it may be property [illegible]
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56090

CERTIFICATE OF DEATH.

92-079

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 141 N. Washington St ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Garrett Walstrum

(a) RESIDENCE. NO. 141 N. Washington ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Walstrum

6 DATE OF BIRTH (month, day, and year) Nov 12, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Robert Cantler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Ellen Stantler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Margaret Wright 141 N. Washington St.

15 Filed Aug 12 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1921, to Aug 10, 1921, that I last saw h alive on Aug 10, 1921, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No.

(Signed) Frank J. Ayd, M. D.

Aug 12, 1921 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aberdeen Md — DATE OF BURIAL Aug 15th 1921

20 UNDERTAKER Leo G. Cook — ADDRESS North st Harford

mation should be entered in plain terms, so that it may be CAUSE OF DEATH in plain terms. See instructions on back of TION is very important.

AUG 12 1921

D 56091 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56091

175-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Franklin Square Hospital St.. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Myrtle Helweick (Helweick)

(Residence in Baltimore: No. 2230 Booth St.; Yrs. 5/12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Sept (Month) 2 (Day), 1896 (Year)

7-AGE.	If LESS than 1 day,
24 yrs. 11 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, James Kelly

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Laura Stewart

13-BIRTHPLACE OF MOTHER (State or Country) Balto City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonard Helwig

(Address) 2230 Booth St

15-

Robert P. Harrison,

Filed....., 191.....

Registrar.

AUG 12 1921 Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 10 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull
Automobile & Motor Cycle
Accident

(Duration)..... yrs..... mos. 2 hrs.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) James M Fulton M. D.
(Coroner.)

Aug 1, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL — DATE OF BURIAL.

Loudon Park Aug 13, 1921

20-UNDERTAKER — ADDRESS

Harry A. Witzke — 1531 W Lombard

D 56092 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56092

CERTIFICATE OF DEATH. X 159

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Common Holt ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Clifton Darrell

(Residence in Baltimore: No. Chesterton Md. St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Mal	Male white	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 43 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) do

9-BIRTHPLACE (State or Country), Md.

PARENTS.

10-NAME OF FATHER Jno C. Darrell

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Mrs Mary Floyd.

13-BIRTHPLACE OF MOTHER (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. J. Pack

(Address) Chestertown, Md.

15-

Filed Aug 13 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol shot wound in left chest.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
(Coroner)

Aug 12, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chestertown, Md	Aug. 13, 1921
20-UNDERTAKER	ADDRESS
E. D. Fanning & Son	1935 E. Lafayette Ave

N.B.—Every item of information should be carefully supplied. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56093

CERTIFICATE OF DEATH.

154 D 56093

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4416 Old Pimlico Rd ST.) (15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anna Fix

(a) RESIDENCE. NO. 4416 Old Pimlico Rd ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip L. Fix

6 DATE OF BIRTH (month, day, and year) Mar. 16- 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo Henricks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christe Bast

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary E Fix (Address) 4416 Old Pimlico Rd

15 Filed AUG 12 1921 19 Robert F. Harrison. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 9th, 1921, to Aug 11th, 1921.

that I last saw her alive on Aug 10th, 1921.

and that death occurred, on the date stated above, at Aug 8a. m.

The CAUSE OF DEATH* was as follows:

Old age Senility

& Weakness (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas H Bubert, M. D.

Aug 11 1921 (Address) 1100 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Kensico Cemetery W. Chester

DATE OF BURIAL Aug 13 1921

20 UNDERTAKER Geo Lewisbach & Son

ADDRESS 647 N. Gilmor St

NOTE.—Write plainly with pen and ink. Information should be carefully supplied as that it may be properly recorded. CAUSE OF DEATH in plain terms, so that it may be properly recorded. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

56094 D 56094

HEALTH DEPARTMENT—CITY OF BALTIMORE

56094 D 56094

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2044 Fountain ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katarzyna Catherine Komoda

(a) RESIDENCE. NO. 2044 Fountain ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanislaus Komoda

6 DATE OF BIRTH (month, day, and year) October 10 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Kolacz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Stanislaus Komoda 2044 Fountain St

15 Filed Aug 13 1921 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 8th, 1921, to Aug 11th, 1921, that I last saw her alive on Aug 11, 1921, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yr. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert S. Kerk, M. D.

Aug 12 1921 (Address) 3126 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: August 13 1921

20 UNDERTAKER: John M. Weber — ADDRESS: 1803 Bank

AUG 13 1921

mation should be carefully supplied, so that it may be properly classified. Each question must be answered, or the word "unknown" or the proper abbreviation inserted. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered, or the word "unknown" or the proper abbreviation inserted. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17937
D 56095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56095

98

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Euzo Errece.

(a) RESIDENCE NO. 1643 Millington St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sarah Terrell.

6 DATE OF BIRTH (month, day, and year) May 3rd 1878 May 3, 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~Old~~	43	3	~~10~~ 4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. Col'd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Charles Terrell

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) ?

14 Informant (Address) Johns Hopkins Hospital Records.

15 Filed AUG 12 1921 19 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12, 1921.

17 I HEREBY CERTIFY, That I attended deceased from August 6, 1921, to Augt 19.

that I last saw him alive on August 11, 1921,

and that death occurred, on the date stated above, at 4 50 A. m.

The CAUSE OF DEATH* was as follows:

Lung abscess

Emfysema

(duration) yrs. mos 28 ds.(?)

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 5 ds.(?)

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Aug 6, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Operation + autopsy

(Signed) Emile Holman, M. D.

8.12.21 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loud County

DATE OF BURIAL August 1921

ADDRESS

20 UNDERTAKER John H Owens

5-38 Dolphin

mation should be carefully supplied, so that it may be properly classified. Exact
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56096

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 56096

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Fritts

(a) RESIDENCE. NO. Charles Town W. Va. WARD. Charlestown W. Va.,

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? 0 yrs. 1 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Fritts

6 DATE OF BIRTH (month, day, and year): Sept 9th 1876

7 AGE — Years: 45 yrs. Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): West Va

PARENTS

10 NAME OF FATHER: Wm Fritts

11 BIRTHPLACE OF FATHER (city or town) (State or country): do not know

12 MAIDEN NAME OF MOTHER: Sallie Trussel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): do not know

14 Informant (Address): P. O. Dyngways Charles Town. W. Va

15 Filed AUG 13 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-12 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-27 1921, to 8-12 1921.

that I last saw him alive on 8-12-1921 1 P. M.

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

osteo-myelitis of nasal septum & hard nasal bones.

(duration) — yrs. 3 mos. 12 ds.

CONTRIBUTORY (Secondary): Haemorrhage (nose)

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes Date of 7-1-21

Was there an autopsy? no!

What test confirmed diagnosis? Microscopic

(Signed) Dudley P. Bowe, M. D.

19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charlestown W Va — DATE OF BURIAL: Aug 13 1921

20 UNDERTAKER: STEWART & MOWEN [illegible] — ADDRESS [illegible] AVE.

CAUSE OF DEATH in plain terms, so that it may be understood by the physician in charge of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-13—H. P. Co.—1000 Bks.

D 56097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56097

CERTIFICATE OF DEATH.

REGISTERED NO. 604

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Mathael

(a) RESIDENCE. NO. 1604 Norwood ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 12 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	0	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md.

PARENTS

10 NAME OF FATHER George Mathael
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md
12 MAIDEN NAME OF MOTHER Emma Umbridge
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Geo Mathias
(Address) 1604 Norwood Ave.

15 Filed AUG 13 1921 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10 . 1921 . to aug 12 . 1921 .
that I last saw him alive on Aug 11 . 1921 .
and that death occurred, on the date stated above, at 1:00 a m.

The CAUSE OF DEATH* was as follows:
Diphtheria — tonsillar — pharyngeal + laryngeal.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Culture positive

(Signed) B. Hoagland M. D.
8/12/21 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Aug 13 1921
20 UNDERTAKER: Mallain Co/C — ADDRESS: 50 E Wash

AUG 13 1921

major should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56098

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE ~~OF~~ DEATH.

108

D 56098

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: NO. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Marsh

(a) RESIDENCE. NO. 1426 Carroll St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 22 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Marsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Edith Kyser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Michigan

14 Informant Edith C. Marsh
(Address) 1426 Carroll

15 Filed Robert J. Harrison, Registrar

AUG 13 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1921, to Aug 12, 1921, that I last saw him alive on Aug 12, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis
Ulcerated

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 11, 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Cyrus D. Lavine, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hayden	Aug 15 1921
20 UNDERTAKER	ADDRESS
Wellman Cole	502 E Balto

mation should be given in plain terms, so that it may be properly coded. CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 56099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56099

167

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 15 W. Woodland St. 27 WARD)

2-FULL NAME Laura V. Jefferson

(a) RESIDENCE NO. 15 W. Woodland ST.; WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 15 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced (or) WIFE of Frank Jefferson

6 DATE OF BIRTH (month, day, and year) Sept 5 1856

7 AGE Years 65 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Winchester Va

10 NAME OF FATHER Unknown

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country) Winchester Va

12 MAIDEN NAME OF MOTHER Rachel Darlington

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Virginia

14 Informant Louis V. Jefferson (Address) 15 W. Woodland

15 Filed AUG 13 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6. 1921. to Aug 11. 1921.

that I last saw her alive on Aug 11. 1921.

and that death occurred, on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia following accidental burns by scalding water

(duration) yrs mos 5 ds.

CONTRIBUTORY (Secondary) Burns of abdomen & legs

(duration) yrs mos. 0 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) James B. Ashmead M. D.

8-11-1921 (Address) 4002 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Aug 15 1921

20 UNDERTAKER William Cook

ADDRESS 502 E. North

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56100

D 56100

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Collison

(a) RESIDENCE. NO. 815 Hanover st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Collison

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory employe

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

086

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Sam. Carroll

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Pinkney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Hospital Records (Address) M. T. H.

15 Filed Aug 19 1921 Robert P. Harrison, Registrar

G 13 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1921, to August 10, 1921, that I last saw her alive on Aug. 10, 1921, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Clyde M. Neil, M. D.

8-10-21 Address Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: Aug 14 1921

20 UNDERTAKER: J. Parham — ADDRESS: 649 W. Lee St.

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 56101

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 56101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 S Bunney ST. 1 WARD)

2-FULL NAME Edward Zbozenski

(a) RESIDENCE. NO. 1117 S Bunney St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) June. 19-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Zbozenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Christina Rothbourka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) James Zbozenski 1117 S Bunneys

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 19 21. to Aug 12, 19 21.

that I last saw h— alive on Aug 12 19 21 at 2.30 p.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Peritonitis Intestinal

(duration) yrs. mon. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wentworth Bunday, M. D.

19 21 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cemetery B	1924

20 UNDERTAKER ADDRESS

Geo. L. Boyd & Chas. J. Faulkner 1-1 Edmondson

B.—WRITE PLAINLY with pen and ink. Age should be carefully supplied. All items of information should be carefully supplied, so that it may be properly classified. Exact CAUSE OF DEATH in plain terms

Spec.—1-10-21—M&T—1500 Bks.

1499 29 D 56102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56102

CERTIFICATE OF DEATH.

+ 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Sofinsky

(a) RESIDENCE ~~No.~~ Glaceland Park, Md. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 20, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
—	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Sofinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Russia

12 MAIDEN NAME OF MOTHER Katie Bridowsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Russia

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed ....., 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

G 13 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1921, to August 12, 1921, that I last saw him alive on August 12, 1921, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos 21+ ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

Aug 17, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Aug 16 1921

20 UNDERTAKER H. Sander & Sons ADDRESS 1710 Pres. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec. 6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56103 28 D 56103

D 56103

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST.. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nelson Sollers

(a) RESIDENCE. NO. 1114 Jenkins Alley ST.. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 023

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Balto

(State or country) Maryland

PARENTS

10 NAME OF FATHER Nelson Sollers

11 BIRTHPLACE OF FATHER (city or town) Unknown, Md

(State or country)

12 MAIDEN NAME OF MOTHER Unknown Eliza Bowles 8-12-21

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country) Unknown

14 Informant Hospital Records

(Address) 1114 Jenkins al

15 Filed ..... 19 ..... Registrar

G 13 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27 . 1921. to August 12. 1921.

that I last saw him alive on August 11. 1921.

and that death occurred, on the date stated above, at 7.05 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Dalaglacey M. D.

19 (Address) Municipal Tbc Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	8/15/21
20 UNDERTAKER J. Leon Hall	ADDRESS 1741 D Ave

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. See back of certificates. TION is very important. See instructions on back.

(James O. Bell)

D 56104 HEALTH DEPARTMENT—CITY OF BALTIMORE 28 D 56104

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 1709 Maryland Ave St. 4 WARD)

2 FULL NAME J. H. Bell

(Residence in Baltimore.) No. 312 Cottage Alley

St.; yrs., 7 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) M

6-DATE OF BIRTH, Unknown (Month), 1 (Day) ..... (Year)

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt

(Address) 312 Cottage Alley

15- Filed ....., 191.. Robert P. Harrison, Registrar.

AUG 13 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 12 (Day), 1911 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from lungs.

Pleurisy 7 D.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Aug 13, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Aug 14 1921

20-UNDERTAKER Edward Engel

ADDRESS 1463 2 Carey

P. S.—Every blank must be filled. CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item important. See instructions on back of certificate.

D 56105 HEALTH DEPARTMENT—CITY OF BALTIMORE 146 D 56105

CERTIFICATE OF DEATH.

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1417 May ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Wm Brunson

(Residence in Baltimore: No. 1417 May St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sgle

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 11 yrs. — mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — gdo
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). md.

PARENTS.

10-NAME OF FATHER, W. Brunson

11-BIRTHPLACE OF FATHER (State or Country). S C.

12-MAIDEN NAME OF MOTHER D Holt Va

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Brunson

(Address) 1417 May St

15- Robert P. Harrison,
Registrar.

AUG 13 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 11, 1914
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Ostio my Ulcus Jeju

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) May be tuberculosis Meningitis or Septicemia

Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Aug 12, 1914 (Address) 1605 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Asbury

DATE OF BURIAL, ..., 1914

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

N.B.—Every item of information must be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D 56106 HEALTH DEPARTMENT—CITY OF BALTIMORE 103 D 56106

56

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2404 Mace St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie I Hopes

(Residence in Baltimore: No. 2404 Mace St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1879 (Year)

7-AGE, 42 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Carter

(Address) 916 Pierce Ave.

15- Robert P. Harrison, 191.....
Burial Permit Clerk.

AUG 13 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug 9 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1a Carcinoma of Liver

.....

.....

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

.....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Blades M. D.
(Coroner.)

Aug 9 1921 (Address) 43 N. Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn

DATE OF BURIAL, Aug 13, 1921

20-UNDERTAKER David Carter

ADDRESS 916 Pierce Ave

N. B.—Every item of information called for in this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56107

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 673 Pierce ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Stewart

(a) RESIDENCE. NO. 673 Pierce ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm E. Stewart

6 DATE OF BIRTH (month, day, and year) Feby 27th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Home work

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Thomas Grant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Beaux Tobacco Step Daughter

(Address) 673 Pierce

15 Filed AUG 13 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 7th, 1921, to Aug 11, 1921, that I last saw her alive on Aug 11, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Not Known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) Samuel A Bain M. D.

1921 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Aug 14 1921

20 UNDERTAKER Annie Torbert

ADDRESS Penn

R.—Name should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of mation should be carefully supplied. AGE should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 56108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 56108
REGISTERED NO. C.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 901 Jordon alley WARD 11)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Mack

(Residence in Baltimore: No. 901 Jordan alley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 5, 1884
(Month) (Day) (Year)

7-AGE, 37 yrs. 8 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Canner

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Mack

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Cathrin Brown

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Burton Yates

(Address) 901 Jordon alley

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

AUG 13 1921 Burial Permit Clerk

N.B.—Every item of information should be carefully given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 12 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ——— (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. F. Hemmeter M. D.
(Coroner.)
Aug 12. 1921 (Address) 28 E Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Aug 15 1921

20-UNDERTAKER David Taylor

ADDRESS 916 Pine

10.56109

D 56109

PLACE OF DEATH.

County Baltimore City Annex

Village or City St. Helena (No. 334, St. Helena St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby. Craig

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH Aug 12th, 1921 (Month) (Day) (Year)

7 AGE 2 Hours

.....yrs. .....mos. .....ds. or .....min. ?

8 OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) St. Helena

PARENTS

10 NAME OF FATHER Stanley Craig

11 BIRTHPLACE OF FATHER (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Imelda Aletter

13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 I HEREBY CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Armstrong

(Address) 334. St. Helena

15 Filed Aug 13 1921 Wm. McCarmmon Registrar

Burial Permit Clerk.

G 13 1921 Burial Permit issued to undertaker named, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

D.S.--Every item of information should be given in plain terms so that it may be properly classified. Exact CIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. statement of OCCUPATION is very important. See instructions on back of certificate.

10.56109

D 56109

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 12, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 12 1921, to Aug 12, 1921.

that I last saw h— alive on Aug 12, 1921.

and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH * was as follows:

Suffocation.
Umbilical cord around neck at birth.

..... (Duration) .....yrs. .....mos. .....ds.

Contributory
Secondary

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Wm. McCarmmon M. D.

..... 192 (Address) Brundale, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....da. In the State, ...yrs. .....mos. .....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL Aug 13th, 1921

20 UNDERTAKER C. F. McCormick ADDRESS 1931 W Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56110

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56110

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 East Cross ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franz Fr. Brehme

(a) RESIDENCE. NO. 315 - E. Cross ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced: HUSBAND of (or) ~~WIFE~~ of Katherine Brehme

6 DATE OF BIRTH (month, day, and year) June 8-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer): O&B

(e) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Freda Schebler

(Address) 315 E - Cross

15 Filed Robert P. Harrison, Registrar

G 13 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 7 1921, to Aug 12 1921, that I last saw him alive on Aug 12 1921, and that death occurred, on the date stated above, at 905 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine, Sputum, Blood

(Signed) Stacy B. Collins, M. D.

Aug 13 1921 (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL 19

20 UNDERTAKER: McCann Co 16

ADDRESS 508 N Eutaw

mation should be carefully supplied, so that it may be properly classified. BLANKS
CAUSE OF DEATH in plain terms. Indefinite and unscientific terms and abbreviations
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56111

CERTIFICATE OF DEATH.

+ 53

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Clifford Currens

(a) RESIDENCE. NO. Thurmont Md ST., ... WARD. Thurmont Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 18 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5 years	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sykesville, Md.

PARENTS

10 NAME OF FATHER Edgar Currens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Toney Co. Md.

12 MAIDEN NAME OF MOTHER Daisy Creager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Thurmont Hoganstown Md.

14 Informant Edward R. Currens

(Address) Sykesville Md

15 Filed AUG 13 1921 . 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5th 1921 to Aug 12th 1921.

that I last saw him alive on Aug 12th 1921.

and that death occurred, on the date stated above, at 1:35 P m.

The CAUSE OF DEATH* was as follows:

Hodgkins disease
secondary myocardial
insufficiency - oedema of the lungs (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sykesville. Md.

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical

(Signed) Wm. Lee Lankford M. D.

. 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Thurmont Frederick Co. Md

DATE OF BURIAL: aug 13 1921

20 UNDERTAKER: Chas. G. Black

ADDRESS: 742 W. Fort Ave

CAUSE OF DEATH in plain terms. So that ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor Janin.

(a) RESIDENCE NO. 123 Market St Tamaqua Pa ST. WARD Tamqua Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 30 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa (State or country)

PARENTS

10 NAME OF FATHER Anthony Janin

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Mary Mony

13 BIRTHPLACE OF MOTHER (city or town) Pa (State or country)

14 Informant Johns Hopkins Hospital Records. (Address)

15 Robert P. Harrison, Burial Permit Clerk. Registrar

G 13-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/13 19 21

17

I HEREBY CERTIFY, That I attended deceased from Aug 8- .1921. to Aug 12 .1921.

that I last saw him alive on Aug 12 .1921.

and that death occurred, on the date stated above, at 8.27 A m.

The CAUSE OF DEATH* was as follows:

Cerebellar tumor

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 12, 1921

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emil Goldman M.D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tamqua Pa	8/13 1921
20 UNDERTAKER	ADDRESS
Jack Leuis	1411 E Balto St

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56113

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56113 ✓

64

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 1115 Madison Ave ST., 11 WARD)

2-FULL NAME Sarah A. Hopkins

(a) RESIDENCE NO. 1115 Madison Ave ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John D. Hopkins

6 DATE OF BIRTH (month, day, and year) July 6 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Granville D. Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER Margaret Baker.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Pearl D. Hopkins. (Address) 1115 Madison Ave.

15 Filed Robert P. Harrison, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 , 1921 , to Aug 11 , 1921 ,

that I last saw her alive on Aug 10 , 1921 , and that death occurred, on the date stated above, at 7 15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) Jno A. Luetscher, M. D.

(Address) 1025 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	8-13 1921
20 UNDERTAKER	ADDRESS
Mr. Chas. A. J. Rohde	658 Arlington Ave

mation should be entered in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

AUG 13 1921 (Burial Permit Clerk.)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56114

D 56114

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 10 W. Conway ST. 77 WARD)

2-FULL NAME Helen Moulden

(a) RESIDENCE. NO. 10 W. Conway ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Richard Moulden

6 DATE OF BIRTH (month, day, and year) April, 12, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundry Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Prince George Co. Maryland.

PARENTS

10 NAME OF FATHER Thomas Briscoe

11 BIRTHPLACE OF FATHER (city or town) Charles Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Henrietta Dyson

13 BIRTHPLACE OF MOTHER (city or town) Prince George's (State or country) Maryland

14 Informant Henrietta Moulden (Address) 10 W. Conway St

15 Filed AUG 13 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug, 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1921, to Aug, 12, 1921, that I last saw h.. alive on Aug, 11, 1921, and that death occurred, on the date stated above, at 9 05 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis Peritoneum, Cachexia

over Sacrum. 6 OVER

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July - 1921

Was there an autopsy? no

What test confirmed diagnosis? at Municipal Hospital

(Signed) David Frankel, M. D.

8/12, 1921 (Address) 22 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: Aug 14 1921

20 UNDERTAKER: J. L. Brown & Son ADDRESS: 1517 Monte

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See back of certificates. TION is very important. See instructions on back.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 56115

HEALTH DEPARTMENT—CITY OF BALTIMORE

56115 D 56115

CERTIFICATE OF DEATH.

152 56115

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 842 W 33rd ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Standfield

(a) RESIDENCE. NO. 842 W 33rd ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 12, 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER George R. Standfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. County, Md.

12 MAIDEN NAME OF MOTHER Elva Mund Crum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City

14 Informant (Address) Geo. R. Standfield Baltimore, Md.

15 Filed AUG 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1921, to Aug 13, 1921, that I last saw him alive on Aug 12, 1921, and that death occurred, on the date stated above, at 7.1 m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

CONTRIBUTORY (Secondary) (duration) yrs. 12 hours mos. ds. Prolonged labor

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A J Dunn, M. D.

(Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Aug 13/21
UNDERTAKER	ADDRESS
J. Walter Davis	3307 Pine St

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. CAUSE OF DEATH is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56116

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. H Johns Hopkins Hosp St.; 15 WARD)

2 FULL NAME Morris Goldberg Goldberg

(Residence in Baltimore: No. 2939 Walbrook ave St.; yrs. Life mos. ds.)

REGISTERED No. C D 56116

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, September 15, 1896 (Month) (Day) (Year)

7-AGE, 25 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Cutter
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Jacob

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Annie Glotzman

13-BIRTHPLACE OF MOTHER (State or Country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jake Lewis

(Address) 1411 E Balto St

15-

Filed AUG 14 1921, 191.... ROBERT J KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 12, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquiry~~.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or ~~inquiry~~) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Autopsy has been made
Pregnant uterus 2 1/2 lbs (Aug 16-
Sarcomatous degeneration of abdomen
2 days (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Usilty M. D. (Coroner.)

Aug 17, 1921 (Address) 1637 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 2 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel

DATE OF BURIAL, Aug 14 1921

20-UNDERTAKER Jake Lewis

ADDRESS 1411 E Balto St

N.B.—Every item of the CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Morris Kolodner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56117

CERTIFICATE OF DEATH.

91

REGISTERED NO. D 56117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~M. Kolodkey~~ M. Kolodner

(a) RESIDENCE. NO. 119 Harrison ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hebrew Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1411 E Balto St.

15 Filed AUG 14 1921 19 ROBERT J. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/13/21 19

17 I HEREBY CERTIFY, That I attended deceased from 8/8/21 . 19 . to 8/13/21 . 19 ,

that I last saw h[illegible] alive on 8/13/21 . 19 ,

and that death occurred, on the date stated above, at 8 50 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Zinberg, M. D.

8/13, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale DATE OF BURIAL 8/14/21

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balto

Make entries on this certificate in plain terms, so that it may be readily understood. CAUSE OF DEATH in plain terms, so that it may be readily understood. CAUSE OF DEATH in plain terms, so that it may be readily understood. CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

Mazzie Harris

150016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56118

CERTIFICATE OF DEATH.

38 D 56118

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

2-FULL NAME Mazzie Harris

(a) RESIDENCE NO. 121 Mulligan ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21y yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married.

5a If married, widowed, or divorced (or) WIFE of Alexander Harris same address

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Balt Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Unknown

14 Informant Johns Hopkins Hospital Records (Address)

15 Date AUG 14 1921 ROBERT J. GRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1921, to Aug 13, 1921, that I last saw her alive on Aug 13, 1921, and that death occurred, on the date stated above, at 12.25 p m.

The CAUSE OF DEATH* was as follows:

Typical Eclock —

Secondary Anaemia —

Double Pyosalpinx

(duration) yrs. 1 mos. ows ds.

CONTRIBUTORY (Secondary) Pregnancy 32 Weeks Disease Typical Eclampsia (duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 8/13/21

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) Frederick Kreuder M. D.

8/13, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Aug 16 1921
20 UNDERTAKER Owre Robert A Elliott	ADDRESS 1725 Ashland Av

malformed children, stillbirths, etc. CAUSE OF DEATH in plain terms, so that it may be classified. ATTENTION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonococcus Infection

Spec.—1-10-21—M&T—1500 Blks.

14996 D 56119

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 56119

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 29 WARD)

2-FULL NAME Jennie Sears

(a) RESIDENCE NO. 182 Falls Road ST., ... WARD .....
(Usual place of abode) W. Roland Park
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Dempsey Sears

6 DATE OF BIRTH (month, day, and year) April 31, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lie in Balt 20 years Virginia

PARENTS

10 NAME OF FATHER Logan Garnett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Fannie Rone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Johns Hopkins Hospital Records

15 AUG 14 1921 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1921

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1921, to August 11, 1921, that I last saw her alive on August 11, 1921, and that death occurred, on the date stated above, at 7:45 a. m.

The CAUSE OF DEATH* was as follows:

Generae peritonitis

(duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Aug 10, 21

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Leo Brady, M. D.

8-11-21, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int-Aurlum Cem

DATE OF BURIAL Aug 14 1921

20 UNDERTAKER Mrs Robert Garnett

ADDRESS 1225 Ashland Av

mation should be ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on back of certificates.

D 56120

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56120

CERTIFICATE OF DEATH.

REGISTERED No. C 159

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 124 Elm ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antoni Ci Kacz

(Residence in Baltimore: No. 124 Elm St.: 8 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single.

6-DATE OF BIRTH, June (Month) 18 (Day), 1898 (Year)

7-AGE, 23 yrs. 1 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Peter Cikacz.

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexander Lawidowicz

(Address) 124 Elm St. Lady

15- AUG 14 1921 Filed....., 191.... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 12 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Gun Shot wound of Head.

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. 1 ds.

(Signed) F. E. Blades M. D.
(Coroner.)

Aug 15 191... (Address) 1437 N. Fremont Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross. Cem Co	Aug 15, 1921
20-UNDERTAKER	ADDRESS
Wm Falkowski	128 Eastern

N. B.—Every item of information called for in CAUSE OF DEATH in plain terms, so that it may be properly classified, is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56121

CERTIFICATE OF DEATH.

D 56121

REGISTERED NO.

1-PLACE OF DEATH U.S.PUBLIC Health Hosp.#56

CITY OF BALTIMORE: (No. Ft.McHenry, Balto.Md. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dick Roy

(a) RESIDENCE NO. USPHS Hosp.#56 Ft.McHenry, ST., Baltimore, Md. WARD 41
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
28	--	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) West Va.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) --
(State or country) --

12 MAIDEN NAME OF MOTHER --

13 BIRTHPLACE OF MOTHER (city or town) --
(State or country)

14 Informant Edgar T.Rosenbrock, Registrar
(Address) USPHS Hosp.#56 Ft.McHenry,Md.

15 Filed AUG 14 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug.13 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct.4,1920, 19..... to Aug.13, 1921.

that I last saw him alive on Aug.13, 19 21,

and that death occurred, on the date stated above, at 1:15 am.

The CAUSE OF DEATH* was as follows:

Carcinoma of scalp (Squanous cell)

Oct. 4,1920 (duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
--- (duration) - yrs. - mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of -

Was there an autopsy? --

What test confirmed diagnosis? Clinical Report

(Signed) Thomas R Payne M. (DR)

, 19 (Address) Thomas RPayne, Senior Surgeon(
Medical Officer in charge

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hurlbull West Va

DATE OF BURIAL Aug 14 21

20 UNDERTAKER Sol Levison

ADDRESS 1127 E Balto St

Information should be carefully written in plain terms, so that it may be properly CODED. CAUSE OF DEATH in plain terms, so that it may be properly CODED. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Castagnola

HEALTH DEPARTMENT—CITY OF BALTIMORE

56122

CERTIFICATE OF DEATH.

84 D 56122

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 S High St ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Castagnola

(a) RESIDENCE. NO. 128 S High St ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) July 18 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) a Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Anthony Castagnola

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maguth Tronzani

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Anthony Castagnola
(Address) 128 S High St

15 Filed AUG 14 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1921, to Aug. 13, 1921, that I last saw him alive on Aug. 13, 1921, and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Bronchitis (Acute)

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Casagno, M. D.

Aug 13, 1921 (Address) 2314 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer	Aug 15 1921
20 UNDERTAKER	ADDRESS
Wendell Heppel & Son	3[illegible] Hanover

CAUSE OF DEATH in plain terms, so that no other cause can be substituted. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 D 56123

D 56123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby of Theresa Bowler

(a) RESIDENCE. No. 1200 St. Matthew ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 11, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 12 hrs. or 6 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Albert Bowler

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Gorman

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant [illegible]
(Address) Johns Hopkins Hospital

15 Filed AUG 14 1921 [illegible] Registrar

[illegible] Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1921, to Aug. 13, 1921, that I last saw her alive on Aug. 12, 1921, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Intracranial haemorrhage following instrumental delivery.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Harris M. D.

Aug. 13 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	8/14/21 19
20 UNDERTAKER H E Stughel	ADDRESS 417 N. Broadway

CAUSE OF DEATH in plain terms. Do not use abbreviations or initials. Name of contagious disease, if any, must be given. Omission to state the CAUSE OF DEATH in plain terms, as directed on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56124

CERTIFICATE OF DEATH.

42 D 56124

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Walnut & Oak St. (Overlea ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian B: Springer.

(a) RESIDENCE. NO. Walnut & Oak St. (Overlea ST..) WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Springer

6 DATE OF BIRTH (month, day, and year) Nov 25th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm H; Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Jacob Springer

(Address) 2428 Jefferson St

15 Filed AUG 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1920, to Aug. 11, 1921.

that I last saw h[illegible] alive on Aug 10 1921.

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Metastasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 1920

Was there an autopsy? Yes

What test confirmed diagnosis? Dr. J. Gibney M. D.

(Signed) Dr. J. Gibney

8/13, 1921 (Address) 6 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 15 1921
20 UNDERTAKER	ADDRESS
J Jennings & Co	2008 Orleans

mation should be written in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

Stephen Dorsey.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56125

CERTIFICATE OF DEATH.

113 D 56125

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 747 W Mulberry ST.; 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen ~~John~~ Dorsey

(a) RESIDENCE. NO. 747 W Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Florence Dorsey

6 DATE OF BIRTH (month, day, and year): 11/27/1858

7 AGE — Years: 62 — Months: 8 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Factory

(c) Name of employer: Swindell's Glass Co

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John S Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Phillip E Dorsey

(Address): 871 Orleans St

15 DATE RECEIVED: AUG 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/12/1921

17 I HEREBY CERTIFY, That I attended deceased from August 2, 1921, to August 12, 1921, that I last saw him alive on August 12, 1921, and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) Indef. yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Norville, M. D.

8/14 1921 (Address) 1197 N Carrollton Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: 8/15/21

20 UNDERTAKER: H. E. Gues.

ADDRESS: 1408 N Eldeery St

CAUSE OF DEATH in plain terms, ... TION is very important. See instructions on back of certificates.

#D56125

Gilmor 4786

PHONE, ~~CHURCH 1720-W~~

W. F. NOVILLE, M. D.
~~707 W. SARATOGA STREET~~
BALTIMORE, MD.

OFFICE HOURS
8 TO 10 A. M
2 TO 4 P. M
7 TO 9 P. M.

1191 N Carrollton Ave 8/15/21

The Health Dept
Balto Md.

The name appearing on death Certificate of John S. Dorsey which was issued by me on 14th inst was found to be a mistake, and should read Stephen Dorsey instead of John S. Dorsey. The accompanying certificate is therefore issued with a view to correcting the error.

W. F. Noville M.D.

Subscribed and Sworn to before me this 15th day of August 1921 that the above to be the truth.

Sophie Kuckamus
Notary Publ.

D 56126

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167

D 56126

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST. 13 WARD)

REGISTERED No. D 56126

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Shirley M. Williamson

(Residence in Baltimore: No. 2705 Parkwood ave, St.: 2 yrs., 11 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	single

6-DATE OF BIRTH. Aug. 22, 1918
(Month) (Day) (Year)

7-AGE. 2 yrs. 11 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Dearing F. Williamson

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Mary V. Clift

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. F. Williamson

(Address) 2705 Parkwood Ave

15-

Filed AUG 14 1921 191.....

ROBERT S KRAUTER
BURIAL PERMIT

Registrar.

CAUSE OF DEATH in plain terms, so that it may be plainly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st, 2nd & 3rd degree burns of body.

(Duration) ....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) Playing with a box of fire.

(Duration) ....yrs.....mos.....ds.

(Signed) J. J. Hennessey M. D.
(Coroner.)

August 14 1921 (Address) 2802 Edgewood ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Md. Gen. Hosp. In the of death....yrs....mos....ds. State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

2705 Parkwood Ave.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	8/15. 1921
20-UNDERTAKER	**ADDRESS**
I. Few McCarthy	130 E. Fort.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56127

D 56127

CERTIFICATE OF DEATH.

X154

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 N Lanvale ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen E. Glassford

(a) RESIDENCE NO. 1933 N Lanvale ST., WARD

(Usual place of abode)

(If non-resident give city or town and State) W. Va

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
about	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James H. Glassford

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER S. J. Clengen

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Dora A. Bissinger

(Address) 1933 N Lanvale St

15 Filed AUG 14 1921 HOWARD B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 13, 1921, that I last saw h alive on Aug 12, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Intestines
General debility

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. A. Morgan, M. D.

, 19 (Address) 1322 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlestown W Va

DATE OF BURIAL Aug 15 1921

20 UNDERTAKER Wallace Cook

ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56128 ✓ 29 D 56128

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women's Hospital ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Jennie Myers

(Residence in Baltimore: No. 501 Forest Rd - Roland Park St.; 63 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
female	white	widow

6-DATE OF BIRTH, January unknown 1850
(Month) (Day) (Year)

7-AGE, 71 yrs. 1 mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Ost

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, Jas. Wallace

11-BIRTHPLACE OF FATHER (State or Country). U S A

12-MAIDEN NAME OF MOTHER Adelaide Johnson

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ella Bowen

(Address) 810 N. Broadway

15- ROBERT J KRAUTH

Filed AUG 14 1921 191.. Registrar.

CAUSE OF DEATH. This line must be filled out. Indefinite answers, such as "Disease of Heart," "Kidney Trouble," "Cancer," "Consumption," "Old Age," are not sufficient. Name the disease causing death, or, in deaths from violent causes, state (1) means of injury; and (2) whether accidental, suicidal, or homicidal. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 10 1921, to August 12 1921, that I saw her alive on August 12 1921, and that death occurred, on the date stated above, at 7 35 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Cystitis ? Myocardial Insuff ?

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank D Worthington M. D.

Aug 14, 1921. (Address) Womens Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 501 Forest Rd - Roland Park.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Leesburg, Va.	8/15/1921
20-UNDERTAKER	**ADDRESS**
W M Cook	507 E North Ave

D 56129

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 56129

REGISTERED No. C 43

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3900 Garrison Ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Rena C. Bunneke

(Residence in Baltimore: No. 3900 Garrison Ave S. 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: October (Month) 6 (Day), 1876 (Year)

7 AGE: 45 yrs. 10 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Home maker
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Hunther

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Marg. Leffler

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm G Bunneke

(Address) 3900 Gorsuch ave

15 Filed AUG 14 1921 ROBERT I KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug. (Month) 13 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 1919, 191.., to Aug 13 1921.

that I saw h.. alive on Aug. 13 1921.

and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast.

(Duration) 1 yr. 10 mos. ds

Contributory (SECONDARY) Metastasis

(Duration) yrs. mos. ds.

(Signed) W. G. Bunneke M. D.

Aug 13, 1921 (Address) 6 E Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Balto. Md.

DATE OF BURIAL: Aug 16, 1921

20 UNDERTAKER: Wm Cook

ADDRESS: 5026 North ave

N. B.-Every item of information should be carefully supplied. Exact statement of the facts may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be understood by the laity. Omissions are very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Wm Lentz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56130

CERTIFICATE OF DEATH.

28 D 56130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 West Lexington St.; 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Lentz

(a) RESIDENCE. NO. 723 W. Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21—1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Painter

(b) General nature of Industry, business, or establishment in which employed (or employer): 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Fredk Lentz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Hensch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Harry Lutz
(Address) 733 W Lexington

15 Filed AUG 14 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1921, to Aug 12, 1921, that I last saw h[illegible] alive on Aug 12, 1921, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Harry Boyd, M. D.

Aug 13-8. 1921 (Address) 602 E Columbus

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cemetery	Aug 15 1921
20 UNDERTAKER: Williams Corp	ADDRESS: 502 E North

CAUSE OF DEATH on plain [illegible] TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56131

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56131

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Carroll & Kennedy Aves. ST.: 217 Washington WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Rachel H. Smith

(Residence in Baltimore: No. Kennedy Ave Cheswolde St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 5, 1859 (Month) (Day) (Year)

7-AGE, 62 yrs. 5 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Wis.

PARENTS.

10-NAME OF FATHER, John Ritto

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), [illegible]

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L. Smith

(Address) Carroll and Kennedy Ave

15- Filed AUG 14 1921 ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19 1921, to Aug 12 1921, that I saw her alive on Aug 11 1921, and that death occurred, on the date stated above, at 11 45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) 4 yrs. mos. ds.

(Signed) Howard L. Hood M. D.

Aug 12, 1921 (Address) 735 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Aug 15, 1921

20-UNDERTAKER Geo J Smith — ADDRESS 1000 N Fayette St

CAUSE OF DEATH. ... important. See instructions on back of certificate.

Spun 6-4-19 M.P. Co.—1000 Bks.

56132

HEALTH DEPARTMENT—CITY OF BALTIMORE

56132

CERTIFICATE OF DEATH.

15 130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1524 Friendship St.; 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sue T. Bald

(a) RESIDENCE. No 1524 Friendship ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William G Bald

6 DATE OF BIRTH (month, day, and year) March 25 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Agnes Burch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant William G Bald

(Address) 1524 Friendship St

15 Filed ..... 19 ..... Registrar

AUG 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1921

17 I HEREBY CERTIFY, That I attended, deceased from Aug 7 1921 to Aug 13 1921, that I last saw h er alive on Aug 13/21 19..., and that death occurred, on the date stated above, at 3 40 p. m.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Abscess in the pelvis

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Miles Wheeler M. D.

7/15 1921 (Address) 2129 W Lanvale ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem Aug 16 1921	

20 UNDERTAKER William Cook ADDRESS 502 E Balto

CAUSE OF DEATH in plain terms. Indefinite or unsatisfactory answers will not be accepted. Every certificate must be complete in all its parts. Omissions will delay burial permit. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

56133D 56133

HEALTH DEPARTMENT—CITY OF BALTIMORE

56133

CERTIFICATE OF DEATH.

150 D 56133

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #827 W Baire ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Harthausen

(a) RESIDENCE. No. 827 W Baire ST., — WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 3/21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Harthausen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Lena B. Vernon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Thomas Harthausen
(Address) 827 W Baire St

15 Filed AUG 15 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13/21 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1921, to Aug 12, 1921, that I last saw h— alive on Aug 12, 1921, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intussusception

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Congenital Heart Disease

(duration) yrs. 5 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Surgical

(Signed) Edward O Sudsburg, M. D.

8/14/21 (Address) 26 N Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: Aug 15 1921

20 UNDERTAKER: F. A. Fraunfelter & Son ADDRESS: 723 Fayette

CAUSE OF DEATH in plain terms. Indefinite answers such as "Heart Failure," "Old Age," "Pneumonia," "Cancer," "Consumption," "Paralysis," "Convulsions," "Dropsy," "Cholera Infantum," "Marasmus," "Debility," "Premature Birth," "Childbirth," "Accident," "Fracture," "Drowning," "Burns," "Scalds," "Suffocation," "Homicide," "Suicide," "Found Dead," "Sudden Death," "Coroner's Case," "Unknown," "Not Known," "Not Attended," "Supposed Typhoid," "Supposed Malarial Fever," "Supposed Scarlet Fever," "Supposed Meningitis," "Supposed Cancer," "Supposed Consumption," "Supposed Paralysis," "Supposed Convulsions," "Supposed Dropsy," "Supposed Cholera Infantum," "Supposed Marasmus," "Supposed Debility," "Supposed Premature Birth," "Supposed Childbirth," "Supposed Accident," "Supposed Fracture," "Supposed Drowning," "Supposed Burns," "Supposed Scalds," "Supposed Suffocation," "Supposed Homicide," "Supposed Suicide," "Supposed Found Dead," "Supposed Sudden Death," "Supposed Coroner's Case," "Supposed Unknown," "Supposed Not Known," "Supposed Not Attended," are not sufficient. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56134

HEALTH DEPARTMENT—CITY OF BALTIMORE

56134 D 56134

CERTIFICATE OF DEATH.

170 56134

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Gately.

(a) RESIDENCE. No. 115 E. Hughes 2H ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Married,

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Mrs. Nona Gately.

6 DATE OF BIRTH (month, day, and year): July 12 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38 yrs.	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland " " "

12 MAIDEN NAME OF MOTHER: Bridget Corbett.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs. Nona Gately 115 E. Hughes St.

15 Filed AUG 15 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-13 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-3 1921 to 8-13 1921

that I last saw him alive on 8-13 1921

and that death occurred, on the date stated above, at 10 45 A.M.

The CAUSE OF DEATH* was as follows:

chr. nephritis

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) edema (duration) — yrs. — mos. 7 ds.

uraemia & pulmonary

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Chemical

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Aug 16 1921

20 UNDERTAKER: T. A. Trance & Son

ADDRESS: Tr. Tanner St

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56135

HEALTH DEPARTMENT—CITY OF BALTIMORE

41

D 56135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #912-Newington-Ave. ST.: 13 (13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Melvina Blair

(a) RESIDENCE. No. #912-Newington-Av. ST.. 13 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? 88 yrs. 6 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James A. Blair

6 DATE OF BIRTH (month, day, and year) Dec-24-1832.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER Peregrine Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Sarah Renshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: Miss Mamie Blair (daughter)
(Address) 912-Newington-Av. City.

15 Filed AUG 15 1921 19 ACKERY & KRAUTER Registrar
Burial Permit Issued

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from January 8, 1921, to August 12, 1921, that I last saw h[illegible] alive on August 12, 1921, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Hubert F. Gillman, M. D.

19 (Address) 1227 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
GREENMOUNT CEMETERY	AUG-16-21

20 UNDERTAKER STE[illegible] MOWEN COMPANY (Address) [illegible] ADDRESS [illegible] N. EUTAW AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 56136

D 56136

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Stiles ST.: 3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Barrett.

(a) RESIDENCE. NO. 1020 Stiles ST., 3rd WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Barrett.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 84 (Years | Months | Days | If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): on

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Michael Louis Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mary E Barrett

(Address): 1020 Stiles

15 Filed AUG 15 1921 Registrar

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 . 1921. to Aug 12 . 1921. that I last saw h er alive on Aug 12 . 1921. and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cancer of face

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arthritis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) A. Palmisano, M. D.

. 19 (Address) 75 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Aug 15 1921

20 UNDERTAKER: E J Bunning & Son, 1938 E Lafayette — ADDRESS

Spec.--6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56137

CERTIFICATE OF DEATH.

X64

D 56137

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1652 Cliftview Av St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emilie Roder.

(a) RESIDENCE. NO. 1652 Cliftview ST., WARD. New York

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yr. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 2nd 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	-			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) London (State or country)

12 MAIDEN NAME OF MOTHER Emilie Swientuett

13 BIRTHPLACE OF MOTHER (city or town) Switzerland (State or country)

14 Informant Mrs E. Schultze

(Address) 1652 Cliftview Ave.

15 Filed AUG 15 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

CAUSE OF DEATH must be plainly written, and TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 1920 to Aug 12 1921,

that I last saw her alive on Aug 11 1921,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy. -

1 (second attack)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo A Strauss Jr. M. D.

8/13. 1921 (Address) 1930 W North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemtry	Aug 15 1921
20 UNDERTAKER	ADDRESS
Geo Lim Bach & Son	647 W Pratt St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56138 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56138

CERTIFICATE OF DEATH. 48

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1922 W Fairmount ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Cassidy

(a) RESIDENCE. NO. 1922 Fairmount ST. 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-11-48

7 AGE Years 72 Months 8 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland Don't know

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Cassidy Son (Address) 1922 W. Fairmount Ave

15 Filed AUG 15 1921 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from 1½ years, 19 . to Aug 12, 19 21.

(that I last saw him alive on Aug 8th 19 21. and (that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Chronic arthritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia St Lawrence

(duration) yrs 3 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

8/17, 1921 (Signed) Dwyt McEvoy, M. D. (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Aug 16 1921

20 UNDERTAKER: Geo Lumbach & Son — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be understood by a layman. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of personsengaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Rheumatic

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56139

CERTIFICATE OF DEATH.

106 D 56139

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Bay View Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Wheeler

(a) RESIDENCE. No. 6515 Fait Avenue ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — - 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly 086

(b) General nature of industry, business, or establishment in which employed (or employer) Hospital

(c) Name of employer Bay View Hospital Baltimore, Maryland

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Charles Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Annie R. Burkas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Edwin E. Wheeler
(Address) 6517 Fait Ave

15 Filed AUG 15 1921 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1921, to August 14, 1921, that I last saw him alive on August 14, 1921, and that death occurred, on the date stated above, at 5:20 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of August 4, 1921

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Francis T. Dalahicy M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 17 1921

20 UNDERTAKER William Cook ADDRESS 502 E Monument

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56140

CERTIFICATE OF DEATH.

9v D 56140

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

2-FULL NAME Anda Pearl Kelly

(a) RESIDENCE. NO. 3410 Elliott ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7-1915

7 AGE: Years 5 | Months 9 | Days 8 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harriston. Va.

PARENTS

10 NAME OF FATHER: Wm. R. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harriston Va

12 MAIDEN NAME OF MOTHER: Lillian Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): William R. Kelly 3410 Elliott St.

15 Filed ..... 19 ..... Registrar

AUG 15 192

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 9 — 1921, to Aug 14 1921, that I last saw her alive on Aug 14 1921, and that death occurred, on the date stated above, at 8:15 a m.

The CAUSE OF DEATH* was as follows: Diphtheria tonsillar + laryngeal

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Cardiac paralysis

(duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Positive culture

(Signed) Bluefarb M. D.

(Address) Sydenham Hospital 8/14/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cem. Augusta Co. Va.

DATE OF BURIAL: Aug 16 1921

20 UNDERTAKER: Lilly & Zitler

ADDRESS: 403 N Wolfe

CAUSE OF DEATH in plain terms. No abbreviations or terms of doubtful meaning. Omission of any item called for on back of certificates. ATTENTION is very important. See instructions on back.

Spec.—1-10-21—M&T—1500 Bks.

56141

HEALTH DEPARTMENT—CITY OF BALTIMORE

56141

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 S. Curley ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman L. Baumer

(a) RESIDENCE NO. 907 S. Curley St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 18- 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country)

PARENTS

10 NAME OF FATHER Thomas E. Baumer.

11 BIRTHPLACE OF FATHER (city or town) Balto City. (State or country)

12 MAIDEN NAME OF MOTHER Mary Behan

13 BIRTHPLACE OF MOTHER (city or town) Balto. City. (State or country)

14 Informant Thomas E. Baumer.
(Address) 907 S. Curley St.

15 Filed AUG 15 1921, 19... ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 12th, 1921, to Aug 17th, 1921, that I last saw him alive on Aug 14th, 1921, and that death occurred, on the date stated above, at 1.35 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. B. Schwatka M. D.

19 (Address) 734 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Aug 15 1921

20 UNDERTAKER Fells & Fuhr

ADDRESS W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56142

D 56142

CERTIFICATE OF DEATH.

40

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3011 Pagson ST., 20 WARD)

2-FULL NAME Mary Miller

(a) RESIDENCE NO. 3011 Pagson ST., 20 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. 4 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Miller

6 DATE OF BIRTH (month, day, and year) Jul 4-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	48	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frederick Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Miller
(Address) 3011 Pagson

15 Filed AUG 15 1921, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to aug 12, 1921, that I last saw her alive on aug 12, 1921, and that death occurred, on the date stated above, at 11.15 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 1 mo yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Examination

(Signed) Wm H A Cot, M. D.

8/11/1921 (Address) 347 Forrest Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug 16 1921
20 UNDERTAKER	ADDRESS
Knell & Son	1729 W Pratt St

mation should be given in answering these questions. It may be prop
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 V

D 56143

REGISTERED No. C

D 56143

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hospital ST., 14 WARD)

2-FULL NAME Hugo Kaplan

(Residence in Baltimore: No. 2220 N. Eutaw St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If Under 1 Year, yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, ..., (Month) (Day), 1 (Year)

7-AGE, 26 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Musician (b) General nature of industry, business, or establishment in which employed (or employer) 080

9-BIRTHPLACE, (State or Country), Balt Md.

PARENTS:

10-NAME OF FATHER, A. Kaplan

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Rut. Jorsky

13-BIRTHPLACE OF MOTHER (State or Country), Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Lewis

(Address) E. Balto St

15- AUG 15 1921 ROBERT J. KRAUER Registrar

Filed ..... 191... Burial Permit filed

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or ~~inquiry~~) thereon and from the evidence obtained by said ..... (Inquest, autopsy or ~~inquiry~~) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: (Inquest will be held Aug 16 21)

P. M. made by Dr. Maddox

Peritonitis due to gun shot wound of abdomen (Duration) ..... yrs. ..... mos. ..... ds.

Dr. Geo. ~~Deale~~ Pneummer

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner.) 1637 Eutaw

Aug 13 1921 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State 2 days yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Zehren Southern Ave

DATE OF BURIAL, 8-16, 1921

20-UNDERTAKER Jack Lewis 1411 E. Balto St

ADDRESS

N. B.—EVERY QUESTION on this certificate must be answered in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. important.

Spec.—1-10-21 M&T 1500 Bks.

D 56144

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Incurable Home 172

CITY OF BALTIMORE (No. 2201 E Balto St., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Harris

(a) RESIDENCE NO. 2201 E Balto St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 16 mos. yrs ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sara Harris

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) old age

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rina —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1441 E Balto St

15 Filed AUG 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1921, to Aug 13, 1921, that I last saw h[illegible] alive on Aug 13 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

senility

concussion of brain (Accl)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) senility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1340 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern ave

DATE OF BURIAL 8/15 1921

20 UNDERTAKER Jack Lewis 1441 E Balto St

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations should not be used. Information must be complete. Omissions will delay issuance of certificates. See instructions on back of certificate. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56145 — 91 — D 56145

1-PLACE OF DEATH — Masonville Md. — REGISTERED NO.

CITY OF BALTIMORE: (NO. 20 Mason St. ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Abraham Arnold.

(a) RESIDENCE. NO. 20 Mason St. ST., 25 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. 25 ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white.	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18/21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child. no

(b) General nature of industry, business, or establishment in which employed (or employer) c

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Ben. F. Arnold.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER C. B. Wyatt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) B. F. Arnold 20 Mason St.

15 AUG 15 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1921, to Aug 13, 1921, that I last saw him alive on Aug 13, 1921, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

Primary (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C A Reifschneider, M. D.

, 19 (Address) 340 S. East Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ceder Hill Cemetery	Aug-15/21
20 UNDERTAKER	ADDRESS
George L Schwab & Bro.	2101 Fredk. Ave.

mation should be entered in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56146

CERTIFICATE OF DEATH.

1207 D 56146

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2404 Jefferson St.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Kuehne

(a) RESIDENCE. NO. 307 S. Regester ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth 25 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert Kuehne

6 DATE OF BIRTH (month, day, and year) Dec 11th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Ethel Wilson

(Address) 302 S. Regester St

15 Filed AUG 15 1921 ..... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 1 - 1921, to Aug 13 1921.

that I last saw h[illegible] alive on Aug 12 1921.

and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Inter Nephritis

(duration) — yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Wassermann

(Signed) G C Cades, M. D.

(Address) 1432 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 15 1921

20 UNDERTAKER Jas C. Miller

ADDRESS 2334 Jefferson

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Staughen

HEALTH DEPARTMENT—CITY OF BALTIMORE

63-001

CERTIFICATE OF DEATH.

D 56147

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 408 N. Robsin ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Staughen

(a) RESIDENCE. NO. 408 N. Robsin ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mah	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Edward Staughen

11 BIRTHPLACE OF FATHER (city or town) Rock Hall
(State or country) Md

12 MAIDEN NAME OF MOTHER Lida E. Foster

13 BIRTHPLACE OF MOTHER (city or town) Stymiteford Co
(State or country) Md

14 Informant Mrs. Lida E. Staughen
(Address) 408 N. Robsin St.

15 Filed AUG 15 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 14, 1921, that I last saw him alive on Aug 13, 1921, at 7.30 a. m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Guard, M. D.

(Address) 3100 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Aug. 15 1921
20 UNDERTAKER	ADDRESS
A. Sandow & Sons	1710 Fleet St.

CAUSE OF DEATH in plain terms, and must be signed by person giving information. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56148 — 92 — REGISTERED NO.

D 56148

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N. Fremont ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Roberts

(a) RESIDENCE. NO. 412 N. Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colred

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Benj. Roberts

6 DATE OF BIRTH (month, day, and year): [illegible] 1896

7 AGE: Years 25 Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Levy Rawlings

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eliza Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Eliza Rawlings 412 N. Fremont Ave

15 Filed AUG 15 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 1921, to Aug 12 1921

that I last saw h alive on Aug 11, 1921

and that death occurred, on the date stated above, at 1.40 a.m.

The CAUSE OF DEATH was as follows:*

Pneumonia Fever

duration yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Nephritis duration yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 412 N Fremont

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albuminuria Symptoms

(Signed) C. H. Fowler M. D.

, 192 (Address) 1125 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 8/15/21

20 UNDERTAKER: J. Fenn W. Goodman — ADDRESS: 1712 Druid Hill Ave

N. B.—WHITE PAPER must be carefully supplied. All questions should be properly answered, so that it may be properly classified. Information should be in plain terms, so that it may be readily understood. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56149

CERTIFICATE OF DEATH.

10 D 56149

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 903 Peach Alley St., 23 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher Collins Jr.

(a) RESIDENCE. NO. 903 Peach ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Beatrice Collins

6 DATE OF BIRTH (month, day, and year) [illegible] 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): O'Neil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Christopher Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Annie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Beatrice Collins
(Address): 903 Peach [illegible]

15 Filed: AUG 15 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 13 21.

that I last saw him alive on Aug 12, 1921

and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows: Cardiac Disease Valvular

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? 903 Peach Alley

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Howell M. D.

, 1921 (Address) 712 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 16 1921
20 UNDERTAKER: John H. Frazier	ADDRESS 1942 Usher St

mation should be given in plain terms, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Pieczynski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56150 + 108 ~ D 56150

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General ST.; WARD)

2-FULL NAME Charles Pieczynski

(a) RESIDENCE. No. Holy Rosary Cemetery WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs 2 mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanislaus Pieczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Honorat Spiack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Honorata Przybyszewska 2618 Edmondson Ave

15 Filed AUG 15 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1921, to Aug 12, 1921.

that I last saw him alive on Aug 12, 1921

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis (14 hours)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Appendicitis (Ruptured) (duration) 3 days

18 Where was disease contracted if not at place of death? Home 8/11/21

Did an operation precede death? Yes Date of Yes

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Wilkinson, M. D.

, 19 (Address) 1001 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	aug 16 1921

20 UNDERTAKER ADDRESS

John A Weber 1803 Bank

MAJOR MORBID CONDITIONS OF DECEASED. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Geneve Goszkowska.

HEALTH DEPARTMENT CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 56151

D 56151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1609 Lancaster ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geneve Goszkowska

(a) RESIDENCE NO. 1609 Lancaster ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	7	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanislaus Goszkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Walerya Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaus Goszkowski
(Address) 1609 Lancaster St

15 AUG 15 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 14 1921

17 I HEREBY CERTIFY, That I attended deceased from aug 11 1921, to aug 12 1921.

that I last saw h alive on aug 12 1921.

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Ileo colitis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

8/15/21 signed W. J. Romanek M. D.

19 (Address) 801 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	aug 15 1921

20 UNDERTAKER John E. Weber ADDRESS 1803 Bank St

mation should be carefully supplied, so that it may be properly classified. Each question must be answered, or the word "unknown" or the proper abbreviation written in every case. Do not use ditto marks. Make no erasures. Typewrite or write with pen and ink and use only permanent black of certificates.
CAUSE OF DEATH in plain terms. Indefinite and unscientific terms cannot be used. Cause of death must be certified to the best of the knowledge and belief of the undersigned.
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 56152

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56152

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 542 Oxford ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Cooper

(a) RESIDENCE NO. 542 Oxford ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: wife of Emma

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 69 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Newton Moton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Polly Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mr. C. S. Downs

(Address): 542 Oxford N

15 Filed AUG 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/13/1921

17 I HEREBY CERTIFY, That I attended deceased from May 5 1921 to aug 13 1921.

that I last saw h alive on aug 12 1921.

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 1 mos 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 8 mos. 4 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins M. D.

8/13 1921 (Address) 101 W Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: Aug 16 1921

20 UNDERTAKER: Geo. H. Holland

ADDRESS: 1631 D. Hillen

N. B.—Information should be carefully supplied. Each item may be properly classified. Exact information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Arthur Littlefield

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56153

CERTIFICATE OF DEATH.

D 56153

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 634 W Fayette St. 4 Ward) REGISTERED No. C 79

2-FULL NAME Arthur Littlefield

(Residence in Baltimore: No. 634 W Fayette St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Unknown

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... Don't Know, 1 .....
(Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Coal Breaker
(b) General nature of industry, business, or establishment in which employed (or employer)..... Coal Mine

9-BIRTHPLACE, (State or Country), Don't Know

PARENTS.

10-NAME OF FATHER, Fr L Littlefield

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Fred

(Address) 63 E Fayette Balto

15-

Filed AUG 15 1921, 191.. BOARD OF HEALTH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug ..... 14 ..., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

Don't know

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch M. D.
(Coroner.)

8-15, 1921 (Address) 517 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Winchester Mass — DATE OF BURIAL, Aug 18 1921

20-UNDERTAKER William Cook — ADDRESS 502 E Balto

N. B.—Every item of information must be given, so that it may be properly classified. Be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Be particular in stating CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56154 — 40 — D 56154

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Agnes Hospital ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Atkinson

(a) RESIDENCE. NO. 322 N. Fulton Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Atkinson.

6 DATE OF BIRTH (month, day, and year) Dec 25 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59 yrs.	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife (87)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Portland Maine

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Bridget Constantine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mr Thurman Atkinson (Address) 322 N Fulton ave

15 Filed ..... 19 ..... Registrar

AUG 15 1921

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 6th, 1921, to Aug 13th, 1921, that I last saw h.. alive on Aug. 13 1921, and that death occurred, on the date stated above, at 8 55 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma stomach

Gall stones.

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Cachexia - acidosis.

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Dudley P. Bowe. M. D.

. 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 16 1921

20 UNDERTAKER James Dignan & Son

ADDRESS 1008 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or ditto marks. Any cause of death which is not a disease should be carefully explained. Any information desired in addition to that called for on this certificate may be given on the back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56155

CERTIFICATE OF DEATH.

28 56155

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1933 Frederick Ave ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilda Cecelia Evans.

(a) RESIDENCE. No. 1933 Frederick Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 13, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Packer.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John J. Evans.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ruth Whitecomb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John J. Evans.

(Address) 1936 Frederick Ave.

15 Filed AUG 15 1921, 19.. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13. 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1921, to Aug 12, 1921, that I last saw h[illegible] alive on Aug 12, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac arrhythmia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward Mandelaum, M. D.

8/13, 1921 (Address) 24 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetary	8/16 1921
20 UNDERTAKER	ADDRESS
Geo. Farnelly	Fulton & Fayette

CAUSE OF DEATH must be plainly written. Any person giving information required in this certificate is liable to prosecution for any false statement. Read carefully the instructions on back of certificates. TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56156 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1752 Park Ave. ST.: 14 WARD) REGISTERED NO. 64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Joseph Handly

(a) RESIDENCE. No. 1752 Park Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (Wife of) Minnie E.Handly

6 DATE OF BIRTH (month, day, and year) Aug 29.1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	1 11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Importer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Handly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Dunn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs E.Ball
(Address) 1752 Park Ave.

15 Filed AUG 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14.1921 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 1919, to Aug 13, 1921, that I last saw him alive on Aug 13, 1921, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Paralysis

(duration) ~~yrs.~~ yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) H.D. Eberhart M. D.

Aug 17, 1921 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8-16-21 19

20 UNDERTAKER H.E.Hughes ADDRESS 424 N.Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. Omissions will delay burial permit. Physicians are required to report cases of death to the Health Department within 24 hours. Neglect to do so is punishable by fine. Name of disease alone is not sufficient. Indefinite terms, such as "Debility," "Old Age," "Natural Causes," "Sudden Death," "Found Dead," "Heart Failure," "Convulsions," "Paralysis," "Cancer," "Tumor," "Abscess," "Child-bed," "Fever," "Inflammation," "Hemorrhage," "Accident," "Suicide," "Homicide," are not sufficient. Deaths from violence must state the means and nature of injury. Deaths from accident, suicide or homicide must be reported immediately to the Health Department. Deaths from contagious diseases must be reported before interment. Deaths occurring without medical attendance must be reported to the Coroner. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92D 56157

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 E.22nd ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Waggner Roberts

(a) RESIDENCE. NO. 403 E. 22nd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced (or) WIFE of Alonzo C.Roberts

6 DATE OF BIRTH (month, day, and year) Aug 8.1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Waggner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary Gunby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Stanley Remington(Son)
(Address) 403 E.22nd St.

15 Filed AUG 15 1921 ROBERT A KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13.1921 19

17

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1921, to Aug 13, 1921, that I last saw h.. alive on Aug 13, 1921, and that death occurred, on the date stated above, at 10:00 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

ovm

(duration) 80 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Wm J Walsh M. D.

Aug 15, 1921 (Address) 2128 St Paul St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	8-16-21 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	434 N.Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the disease causing death, or in deaths from violence, the means and nature of injury, is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56158

CERTIFICATE OF DEATH.

150 D 56158

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N. Belnord Ave ST.: WARD)

2-FULL NAME Anna Eliz. Kegan

(a) RESIDENCE. NO. 215 N.Belnord Ave ST., WARD.
(If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug.5.1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Julius S.Kegan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Louise Fsitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Julius S.Kegan
(Address) 215 N.Belnord Ave.

15 Filed AUG 15 1921 ROBERT I KRAUTER Registrar
Burial ...e.: Glen

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14/ 19 21

17 I HEREBY CERTIFY, That I attended deceased from Aug 13 19 21, to Aug 14 19 21,
that I last saw h alive on Aug 14 19 21.
and that death occurred, on the date stated above, at 12.20 P. m.
The CAUSE OF DEATH* was as follows:

Congestion
Obstruction of Gall Bladder
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) E. H. Meyer M. D.

8/14 19 21 (Address) 1638 E. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	8-15-21 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 56159

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Murphy

(a) RESIDENCE. NO. 1329 N Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary E Beck
(Address) 1329 N Broadway

15 Filed AUG 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1921. to Aug. 13, 1921

that I last saw h[illegible] alive on Aug 13, 1921.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. W. Kourey, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cemetery	Aug 16 1921
20 UNDERTAKER	ADDRESS
Robt Kane Sr	1442 N. Broadway.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Amos J. Rappold

HEALTH DEPARTMENT—CITY OF BALTIMORE

56160

CERTIFICATE OF DEATH.

170D 56160

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1533 Orleans ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amos J. Rappold

(Residence in Baltimore: No. 1533 Orleans St.: 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH, Oct 30 (Month) (Day), 1851 (Year)

7-AGE, 70 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tanner
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jane Rappold

(Address) 1533 Orleans

15- Filed ..., 191... Registrar.

ROBERT J. BRAUTER

G 15 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 12 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1921, to Aug 12 1921, that I saw h[im] alive on Aug 11 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Pneumonia

(Duration) 20 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Goodman M. D.

Aug 13, 1921 (Address) 3108 Hospital R.d.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Mathews — DATE OF BURIAL, Aug 15..., 1921.

20-UNDERTAKER W M B Callender — ADDRESS Bank & Amity

CROSS OUT anything not important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 56161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 56161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 S Wolfe St. ST.; V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Covacevich

(a) RESIDENCE. NO. 906 S Wolfe ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29.

7 AGE: Years 60 Months 8 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Capt of Ship

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Australia

PARENTS

10 NAME OF FATHER Antone Covacevich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austrialia

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Australia.

14 Informant: Mary Covacevich

(Address) 906 S Wolfe St.

15 Filed AUG 15 1924 Burial r. m. Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 12 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1921, to August 12th, 1921, that I last saw him alive on August 12th, 1921, and that death occurred, on the date stated above, at 7.45A m.

The CAUSE OF DEATH* was as follows:

Chronic Interst Nephr.

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopical.

(Signed) August Horst, M. D.

, 19 (Address) 40 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 16 1924
20 UNDERTAKER: J M B Callender	ADDRESS: Baltimore

MAKE ENTRIES with pen and ink, and write plainly. Be sure to fill all blanks properly. Do not abbreviate. CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Anna J. Kuczewski

D 56162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56162

CERTIFICATE OF DEATH

104

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 712. S. Montford Ave ST.: 1 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Anna J. Kuczewski

(Residence in Baltimore: No. 712. South Montford Ave St.: yrs. 6 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6 DATE OF BIRTH January 12, 1921.
(Month) (Day) (Year)

7 AGE yrs. 6 mos. 23 ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Kuczewski

11 BIRTHPLACE OF FATHER (State or country) Poland, Europe.

12 MAIDEN NAME OF MOTHER Magret Stromer,

13 BIRTHPLACE OF MOTHER (State or country) Baltimore. Md,

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Maggie Kuczewski
(Address) 712 S. Montford Ave.

15 Filed AUG 15 1921 ROBT. J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 14, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 14, 1921. to. August 14 1921.
that I saw her alive on August 14 1921.
and that death occurred, on the date stated above, at 10. a.m.
The CAUSE OF DEATH* was as follows:
Entero — Colitis.

(Duration) 6 yrs. 6 mos. 7 ds

Contributory (SECONDARY) Exhaustion

(Duration) 6 yrs. 6 mos. 7 ds.

(Signed) Dr. Frederick G. Stromer M. D.
August 15, 1921. (Address) 112. S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Stanislaus Cem. | DATE OF BURIAL Aug 16" 1921.

20 UNDERTAKER M. F. Sadowski | ADDRESS 705 S. Ann St

N. B.—Every item of information should be carefully supplied. Also state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

149 33
D 56163

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 56163
REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. John Hopkins Hospital ST., 9 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph McGrath.

(a) RESIDENCE NO. 1907 E Chase St. Balto. Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — 087
(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10 NAME OF FATHER Edward McGrath
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Elizabeth Cody
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed AUG 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 7 . 1921 . to Aug 13 . 1921 .
that I last saw him alive on Aug 13 . 1921 .
and that death occurred, on the date stated above, at 5 35 A m.

The CAUSE OF DEATH* was as follows:
Myocardial insufficiency

(duration) 2½ yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, cystic kidneys
(Cause) Aneurysm (duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Geo. L. Thomas Jr., M. D.

8-12, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral St. — DATE OF BURIAL Aug 16 1921

20 UNDERTAKER Geo M. Smith & Son — ADDRESS 821 N Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56164

CERTIFICATE OF DEATH.

D 56164

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3954 Falls Road ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eldren E. Ruff

(Residence in Baltimore: No. 3954 Falls Road St.; 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH April (Month) 4 (Day), 1866 (Year)

7-AGE 55 yrs. 4 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Moulder
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Co.

PARENTS.

10-NAME OF FATHER, Frederick Ruff.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Olivia Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie L. Ruff

(Address) 3954 Falls Rd

15- Filed AUG 15 1921, 191... Burial Permit Issued: ROBERT J. KRAFFT Registrar

CAUSE OF DEATH must be plainly written. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 15th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Aug 15 1921, that I saw him alive on aug 15 1921, and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Nephritis

(Duration) 1 yrs, mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) 10 yrs. mos. ds.

(Signed) D. R. Wantz M. D.

Aug 15 1921 (Address) 865 W. 36th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, Aug 15, 1921

20-UNDERTAKER J. S. Marshall ADDRESS 3390 Falls Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56165

CERTIFICATE OF DEATH.

191

D 56165

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 220 E. Barney ST. (or) 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna M. Keefe

(a) RESIDENCE. NO. 220 E. Barney ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 19, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John L. Keefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Margaret Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant John L. Keefe (Address) 220 E Barney

15 Filed AUG 15 1921 Burial Permit [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1921, to Aug 12, 1921, that I last saw h alive on Aug 11, 1921 and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Primary (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H. C. Campbell, M. D.

Aug 14, 1921 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cem.

DATE OF BURIAL Aug 15 1921

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Eight St.

CAUSE OF DEATH in plain terms, so that it may be understood by all persons. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56166

REGISTERED NO. D 56166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3532 Chestnut Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Lovell

(a) RESIDENCE. NO. 3532 Chestnut Ave. ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of Eliza Lovell

6 DATE OF BIRTH (month, day, and year) July 12-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Spinner (Cotton Mill)

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 15 years. 046

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Maryland

PARENTS

10 NAME OF FATHER Wm. Lovell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Betsie Lovell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Mrs. Eliza Lovell 3532 Chestnut Ave

15 FILED AUG 15 1921 ROBERT J. CARTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from August 11th, 1921, to August 12, 1921, that I last saw h[illegible] alive on August 11th, 1921, and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William H. Clopton, M. D.

, 19 (Address) 2419 Huntingdon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys (Stampden) DATE OF BURIAL Aug. 16 1921

20 UNDERTAKER Horace H. Burgee ADDRESS 3631 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Stec.—6-9-19—H. P. Co.—1000 Bks.

D 56167 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 E. 33rd ST.: 12 WARD) 79 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Kirk

(a) RESIDENCE. NO. 205 E. 33th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Samuel E. Kirk

6 DATE OF BIRTH (month, day, and year) Jan 22 - 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	86	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Cole

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Clark

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Maryland

14 Informant Charles E. Kirk
(Address) 2803 Guilford Ave

15 Filed AUG 15 1921, 19 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH 1. P.M.

16 DATE OF DEATH (month, day, and year) Aug 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from November, 1919, to Aug. 14, 1921, that I last saw h[illegible] alive on Aug. 14, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George A. Hartman, M. D.

Aug 15, 1921 (Address) 2201 Wyndhurst Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug 16 1921

20 UNDERTAKER John B. Spencer ADDRESS 1825 N. Gaulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Dec. 6-9-19 H. P. Co.—1000 Bks.

D 56168 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56168

CERTIFICATE OF DEATH. X 104

1-PLACE OF DEATH Nursery & Childs Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. Franklin & Schroeder ST.S 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Tucker

(a) RESIDENCE. No. Nursery & Childs Hospital ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, ~~or Divorced~~ (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec-29-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		7	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby - girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis, Md.

PARENTS

10 NAME OF FATHER William Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto - Md.

12 MAIDEN NAME OF MOTHER Margaret Tuite

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South River Md.

14 Informant Mrs. George Hutton (Address) N.B.C. Hospital

15 Filed AUG 15 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13 - . 1921. to Aug 15 . 1921.

that I last saw him alive on Aug. 14 - . 1921.

and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Acute Sleo-Colitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No —Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mae J. Ziegler, M. D.

, 19 (Address) 2006 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 16 19 21
20 UNDERTAKER George J. Smith	ADDRESS 1000 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks. 56169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 56169

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Serr

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed AUG 15 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 11 1921

17 I HEREBY CERTIFY, That I attended deceased from August 11 1921 to August 11 1921

that I last saw him alive on August 11 1921

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ½ ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 1 mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde Mitchell, M. D.

8/12/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL AUG 1 1921

ADDRESS

20 UNDERTAKER Commissioner Health.

PAT. WM. E. WOODALL

CAUSE OF DEATH in plain terms. So that it may be classified. See back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56170 ✓ 175-004 D 56170

1-PLACE OF DEATH D 56170 26 175 REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital, Bay View STREET WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. Snyder

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Helen Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records, (Address) New City Hospital.

15 Filed AUG 15 1921 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 10 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 13, 19 21, to August 10, 1921, that I last saw him alive on August 10, 1921, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

1 Day (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paraplegia (Traumatic)

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. E. Broadhurst, M. D.

8/11/19 21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER Commissioner Health.	ADDRESS AUG 15 1921

UNIVERSITY OF MARYLAND

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. Do not use abbreviations or technical terms. Do not state mode of dying, such as heart failure, asphyxia, etc., but the disease or injury which caused death. Name contributory (secondary) causes, if any, which aggravated the principal disease or injury. Operations should be stated only when performed for some other disease than that which caused death. Write plainly with ink. Fill in all blanks with the best information obtainable. Physicians are requested to fill in certificates. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 56171

D 56171

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rector

(a) RESIDENCE. NO. 878 McKimp st. ST. ..... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Rector

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Porter - 08

(c) Name of employer

9 BIRTHPLACE (city or town) Livin Balt- 25 years
(State or country) West Virginia

PARENTS

10 NAME OF FATHER Anderson Green

11 BIRTHPLACE OF FATHER (city or town)
(State or country) West Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) West Virginia

14 Informant Hospital Records
(Address) M.T.H.

15 Filed AUG 13 1921 BOARD OF HEALTH Registrar
Burial Permit 34665

CAUSE OF DEATH in plain terms, so that it may be properly classified. (See reverse side for additional information.) Do not use abbreviations or terms which are not generally understood. Indefinite or unsatisfactory answers will be returned for correction. Statements of contributory causes of death are desired. INFORMATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13, 1921

17

I HEREBY CERTIFY, That I attended deceased from July 23, 1921, to Aug. 13, 1921, that I last saw him alive on Aug. 13, 1921, and that death occurred, on the date stated above, at 8.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Dalaglaire M. D.

8-13-21 (Address) Municipal Tbc Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery

DATE OF BURIAL Aug 15 1921

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56172 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56172

CERTIFICATE OF DEATH.

81

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 Liguard ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Heiner

(a) RESIDENCE. NO. 20 Liguard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 29-1845

7 AGE: Years 76 | Months 4 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Johanna Heiner 20 Liguard ST

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1920, to Aug 14, 1921, that I last saw her alive on Aug 13, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Senile

(duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) C. K. Skilling, M. D.

8-15, 1921 (Address) 4107 Lenly Hgts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Aug 16. 1921
20 UNDERTAKER Chas. W. Dill.	ADDRESS 3109 Frdk. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56173

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincents Orphanage ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Zebron

(a) RESIDENCE. NO. 1401 Division ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Odd.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) 1401 Division St. Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Geo Smith

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Julia Zebron

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant David N. Ingram
(Address) St. Vincents Infant Asylum

15 Filed AUG 15 1921, 19 Robert P. Hayden Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1921, to Aug 11, 1921, that I last saw him alive on Aug 9, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Ileo colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Examination

(Signed) Stanley W. Mallhews M. D.

, 19 (Address) Bal. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Aug 15 1921

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1827 W North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56174

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56174

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Vincents Orphanage ST.: 14 WARD)

2-FULL NAME John murphy

(a) RESIDENCE. NO. 140 Division ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) June 18, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Sold

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Maryland

PARENTS

10 NAME OF FATHER John Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) not Known

12 MAIDEN NAME OF MOTHER Fannie (not known)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant David M. Ingram
(Address) St. Vincents Infant Asylum

15 Filed . 19 Robert P. Harrison, Registrar

G 15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 21, to Aug 13, 21.

That I last saw him alive on Aug 13, 21.

and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Ileo colitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) malnutrition

(duration) yrs. mos. bowel ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) Stanley W. Matthews, M. D.

, 19 (Address) Bal. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Aug 15 1921

20 UNDERTAKER Martin Fahey Jr & Sons ADDRESS 1827 N Caroline St

CAUSE OF DEATH in plain terms, so that it may be understood by the people. See back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56175

D 56175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N Mother ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Reardon

(a) RESIDENCE. NO. 124 N Mother ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Dennis Reardon

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 54; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pikesville Md

PARENTS

10 NAME OF FATHER: Thomas Killakka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Barron

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Dennis Reardon 124 N Mother St

15 Filed AUG 15 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1920 to Aug 14 1921

that I last saw her alive on Aug 14 1921

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(duration) yrs. 8 mos. 15 ds.

CONTRIBUTORY (Secondary): Gangrene of toe (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathologic

(Signed) Irvin Ebaugh, M. D.

Aug 15 1921 (Address) 700 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Aug 17 1921

20 UNDERTAKER: Martin Fisher & Sons — ADDRESS: 827 N Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

14995 D 56176

CERTIFICATE OF DEATH.

D 56176

64

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 11 WARD)

2-FULL NAME Wm D. Jones

(a) RESIDENCE NO. 210 W. Monument St ST., City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs. Elizabeth Brooks Jones. maiden address.

6 DATE OF BIRTH (month, day, and year) March 5th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Francis S. Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriett Downey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital Records (Address) Robert T. Harrison, Jr.

Filed AUG 15 1921 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 6 . 1921 . to Aug 14 . 1921 .

that I last saw him alive on Aug 14 . 1921 .

and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis

Apoplexy

? (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Morgan, M. D.

8-14-21 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Aug 16 1921

20 UNDERTAKER John O Mitchell

ADDRESS 1701 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56177

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56177

176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland General Hospital ST.; WARD)

2-FULL NAME Ludwig L. Emmerich.

(a) RESIDENCE. NO. 1417 W. Lombard St.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or Wife of)~~ Ellen J. Emmerich

6 DATE OF BIRTH (month, day, and year) Aug 30, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	57	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Ludwig Emmerich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizetta Bruning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) James L. Emmerich 1417 W. Lombard

15 Filed AUG 15 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 5th, 1921, to Aug 14, 1921, that I last saw h~~e~~r alive on Aug 14, 1921, and that death occurred, on the date stated above, at 12.40 P.M.

The CAUSE OF DEATH* was as follows:

Hypertrophy of the prostate gland

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralytic Intestinal Obstruction (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 8, 1921

Was there an autopsy? No

What lest confirmed diagnosis? Clinical

(Signed) John W. Metcalf, M. D.

19 (Address) Maryland Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 17 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificates without CAUSE OF DEATH or with indefinite terms, such as "Heart Failure," "Old Age," "Senility," "Exhaustion," "Convulsions," "Paralysis," "Cancer," "Tumor," "Abscess," "Blood Poisoning," "Septicemia," "Pyemia," "Uremia," "Meningitis," "Tuberculosis," "Consumption," "Pneumonia," "Bronchitis," "Pleurisy," "Hemorrhage," "Jaundice," "Dropsy," "Debility," "Malnutrition," "Marasmus," "Infantile Disease," "Childbirth," "Miscarriage," "Abortion," "Accident," "Injury," "Fracture," "Drowning," "Burns," "Scalds," "Asphyxia," "Suffocation," "Strangulation," "Poisoning," "Shock," "Hemorrhage," "Coma," "Unknown," "Undetermined," "Not Known," "Not Stated," "Not Given," "Not Ascertained," "Not Diagnosed," "Not Specified," "Not Certified," "Not Recorded," "Not Reported," "Not Available," "Not Applicable," "None," "Nil," "N/A," "—," "?," "Unknown Cause," "Undetermined Cause," "Not Known Cause," "Not Stated Cause," "Not Given Cause," "Not Ascertained Cause," "Not Diagnosed Cause," "Not Specified Cause," "Not Certified Cause," "Not Recorded Cause," "Not Reported Cause," "Not Available Cause," "Not Applicable Cause," "None Cause," "Nil Cause," "N/A Cause," "— Cause," "? Cause," "Unknown Cause of Death," "Undetermined Cause of Death," "Not Known Cause of Death," "Not Stated Cause of Death," "Not Given Cause of Death," "Not Ascertained Cause of Death," "Not Diagnosed Cause of Death," "Not Specified Cause of Death," "Not Certified Cause of Death," "Not Recorded Cause of Death," "Not Reported Cause of Death," "Not Available Cause of Death," "Not Applicable Cause of Death," "None Cause of Death," "Nil Cause of Death," "N/A Cause of Death," "— Cause of Death," "? Cause of Death

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56178

D 56178

CERTIFICATE OF DEATH.

89

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 E Hamburg ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma V. Story

(a) RESIDENCE. NO. 104 E Hamburg ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Wm J. Story

6 DATE OF BIRTH (month, day, and year) March 7 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas H. Hersch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah Ebert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John Byrne

(Address) 104 E Hamburg St

15 Filed Aug 19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 8 1921 to Aug 17 1921 that I last saw h[illegible] alive on Aug 13 1921 and that death occurred, on the date stated above, at 3.20 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Old age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. M. Fields M. D.

Aug 19 1921 (Address) 1279 Pulliam St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk. Cem.	Aug 17 1921
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light St.

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT ADDRESS must be given. See instructions on back of certificates.

D 56179 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56179

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1021 Fulmayne Nurses Home St.) (WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred J. Bonlay

(Residence in Baltimore: No. 1152 Longwood St.) (If non-resident, give usual place of abode.) (Age: 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 19 (Day), 1856 (Year)

7-AGE, 65 yrs. 2 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 66

9-BIRTHPLACE, (State or Country), Canada

PARENTS.

10-NAME OF FATHER, John A. Bonlay

11-BIRTHPLACE OF FATHER (State or Country), Canada

12-MAIDEN NAME OF MOTHER, Philomene Rivard

13-BIRTHPLACE OF MOTHER (State or Country), Canada

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond J. Bonlay

(Address) 1152 Longwood St

15-

Filed Aug. 15, 1921 Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease (Duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know (Duration) yrs. mos. ds.

(Signed) W. R. Jarrett M. D. (Coroner.)

Aug. 15, 1921 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Aug. 16, 1921

20-UNDERTAKER Marguet J. Flynn ADDRESS 1712 Light St.

AUG 15 1921 Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56180

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 W. 28th St. WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Stokes

(a) RESIDENCE. NO. 300 W 28th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 13-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lillian Wind

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — —

14 Informant (Address) Wm Stokes 300 W 28th St

15 Filed Aug 15 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 1921, to Aug 14 1921, that I last saw him alive on Aug 14 1921, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) own

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edw C Carper, M. D.

, 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lochstoned. Co — DATE OF BURIAL Aug 15 1921

20 UNDERTAKER Samuel Hendley ADDRESS 518 Bible

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fill in all items. Use ink. Write plainly. Do not abbreviate. Be sure to sign certificate. Name of informant may be required on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56181

28

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1617 Latrobe ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine J Long

(a) RESIDENCE. No. 1617 Latrobe ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. — mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER David Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Martha Long (mother)
(Address) 1617 Latrobe Street

15 Filed AUG 15 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1921, to Aug 13, 1921, that I last saw h.r alive on August 13, 1921, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tubercular Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) L. J. Young, M. D.

, 19 (Address) 1416 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Royal Oak Md	Aug 15 1921
20 UNDERTAKER Samuel S Hensley	ADDRESS 1118 Bolton

CAUSE OF DEATH in plain terms, so that it may be properly Classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56182

CERTIFICATE OF DEATH.

45

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1609 Clifton Place (WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Gilbert

(a) RESIDENCE. NO. 1609 Clifton Place ST. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha M. Gilbert

6 DATE OF BIRTH (month, day, and year) August 2nd 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67.	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Harford County Md

PARENTS

10 NAME OF FATHER Geo. T. Gilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md Harford County

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md Harford County

14 Informant Stanley E. Gilbert. (Address) 1609 Clifton ave

15 Filed AUG 15 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1921, to Aug. 13, 1921, that I last saw h.. alive on Aug. 12, 1921, and that death occurred, on the date stated above, at 8:40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Metastases

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Cystoscopic Examination

(Signed) Albert Singewald, M. D.

8/24 1921 (Address) 1613 E. Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hartley Chapel Harford Co	Aug. 16 1921

20 UNDERTAKER — ADDRESS

George J. Ruth — 1735 Harford ave

CAUSE OF DEATH in plain terms, so that it may be ... of certificates. TION is very important. See instructions on back of ...

Spec.—8-24-14—M. & T.—2000 Bks.

D 56183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56183

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2006 Druid Hill Ave St.; 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Johnson

(Residence in Baltimore: No. 2006 Druid Hill Ave St.; 20 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 22 nd, 1867
(Month) (Day) (Year)

7-AGE, 54 yrs. 5 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, John Johnson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Lilly

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Johnson

(Address) 2006 Druid Hill Ave

15- Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk, Registrar.

UG 15 1921

CAUSE OF DEATH to be plain here, and important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 13th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 28 1921, to Aug 13th 1921, that I saw h.. alive on Aug 13th 1921, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyemia (over)

(Duration) yrs. mos. ds.

(Signed) Harry F. Brown M. D.

Aug 13 1921. (Address) 1501 Presstman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Aug. 16 1921

20-UNDERTAKER John H. Tradin — ADDRESS 142 N. Gilmor St

toe on Left foot, then to deep muscles of Front of thigh (abscess forming there, and under arms (in Axilla) Dr H F Brown.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56184

D 56184

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 567 Moore ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Vandeford

(a) RESIDENCE. NO. 567 Moore St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jerome Vandeford

6 DATE OF BIRTH (month, day, and year) May 11, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3	1	

49

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jno. Ford (Address) 567 Moore St

15 Filed Aug 15 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1921, to Aug 12, 1921, that I last saw her alive on Aug 8 12, 1921, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy,

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. T. Pelteacan, M. D.

19 (Address) 829 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Aug 16 1921

20 UNDERTAKER John H. Toadvine

ADDRESS 142 Uhler St

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56185 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56185

CERTIFICATE OF DEATH. 14

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry C. Hesse

(a) RESIDENCE. NO. 1740 Chase St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Caroline Gluck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital

15 Filed AUG 15 1921 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to August 14, 1921

that I last saw him alive on August 13, 1921.

and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Dysentery -- Etiology unknown

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Fracture Neck Femur

(duration) yrs. 2 mos. 14 ds.

18 Where was disease contracted if not at place of death? at home of Death.

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) E. E. Broadhurst, M. D.

8/14/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Aug. 16, 1921

20 UNDERTAKER Wm Cook ADDRESS 5026 E. North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bloody Stool. Organism not
Isolated.
Typhoid + fell in room.
Injuries not severe.

Spec.—1-10-21—M&T—1500 Blks.

D 56186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56186

CERTIFICATE OF DEATH.

120

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 445 E Lanvale ST., 17 WARD)

2-FULL NAME Mary F Ruschmeyer

(a) RESIDENCE NO. 445 E Lanvale ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Ruschmeyer

6 DATE OF BIRTH (month, day, and year) Aug 14 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel H Ruschmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Regina Rosenmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Bertha F Frank

(Address) 445 E Lanvale St

15 Filed AUG 15 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to Aug 15, 1921, that I last saw h.. alive on Aug 15, 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. K. Campbell M. D.

(Address) 1647 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill DATE OF BURIAL Aug 18 1921

20 UNDERTAKER W. M. Cook & Noble ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56187

CERTIFICATE OF DEATH.

D 56187

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 N. Central Ave ST.: 5 WARD)

REGISTERED NO. 104

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Cenithia Martin

(a) RESIDENCE. No. 403 N. Central Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease alone is insufficient. Indefinite terms, such as "Debility," "Old Age," "Senility," "Exhaustion," "Heart Failure," "Convulsions," "Paralysis," "Cancer," "Tumor," "Abscess," "Child-birth," "Accident," "Fracture," "Injury," "Burns," "Drowning," "Found Dead," "Killed," "Murder," "Suicide," "Poisoning," "Unknown," "Stillborn," "Premature Birth," "Still Birth," "Congenital Debility," "Marasmus," "Inanition," "Malnutrition," "Teething," "Lockjaw," "Blood Poisoning," "Septicemia," "Pyemia," "Uremia," "Meningitis," "Hydrocephalus," "Tuberculosis," "Pneumonia," "Bronchitis," "Pleurisy," "Peritonitis," "Enteritis," "Colitis," "Nephritis," "Kidney Disease," "Liver Disease," "Valvular Disease," "Heart Disease," "Aneurism," "Hemorrhage," "Thrombosis," "Embolism," "Apoplexy," "Cerebral Hemorrhage," "Cerebral Embolism," "Cerebral Thrombosis," "Cerebral Softening," "Locomotor Ataxia," "Epilepsy," "Tetanus," "Hydrophobia," "Rheumatism," "Diabetes," "Scarlet Fever," "Typhoid Fever," "Measles," "Whooping Cough," "Chicken Pox," "Smallpox," "Diphtheria," "Erysipelas," "Influenza," "Malaria," "Dysentery," "Cholera," "Yellow Fever," "Spinal Meningitis," "Cerebro-Spinal Meningitis," "Spotted Fever," "Typhus Fever," "Scurvy," "Rickets," "Gangrene," "Mortification," "Carbuncle," "Ulcer," "Bed Sore," "Abortion," "Miscarriage," "Childbirth," "Puerperal Fever," "Puerperal Septicemia," "Puerperal Convulsions," "Puerperal Hemorrhage," "Puerperal Peritonitis," "Puerperal Abscess," "Puerperal Pyemia," "Puerperal Uremia," "Puerperal Eclampsia," "Puerperal Mania," "Puerperal Thrombosis," "Puerperal Embolism

Ardella Hill

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56188

D 56188

CERTIFICATE OF DEATH.

50 ✓ 5

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1429 Jefferson ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ardella Hill

(a) RESIDENCE. NO. 1429 Jefferson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred over 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Hill

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
#1	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work "Housework"

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anundel Co' Md lived in Balt 45 yrs and upward

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary J. Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant R. A. Elliott

(Address) 726 Rogers ave.

15 Filed AUG 16 1921 19 MOSES J. KRAFTER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 13 Aug. 1921.

17 I HEREBY CERTIFY, That I attended deceased from about a year ago to date that I last saw h[illegible] alive on 13 Aug. 1921. and that death occurred, on the date stated above, at 1 30 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes about a year (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia, Coma, (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto, Md.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Benedict's etc

(Signed) Clifford Taylor M. D.

8/8 1921 (Address) 425 N. Carrollton Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt-Auburn Cem

DATE OF BURIAL Aug 16 1921

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1726 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Lamot

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 56189

CERTIFICATE OF DEATH. 104

D 56189

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 E. Heath ST.: 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Mildred Lamott

(a) RESIDENCE. NO. 233 E. Heath. ST. 24th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
female	white	Infant.

5a If married, widowed, or divoreed
HUSBAND) of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 15, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 640

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Saml J. Lamott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nellie C. Brophy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Saml J. Lamott
(Address) 233 E. Heath St

15 Filed AUG 16 1921 19 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1921. to Aug 15, 1921, that I last saw her alive on Aug 14, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis.

(duration) 0 yrs. 0 mos. 9 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

19 (Address) 1049 Riverside Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL Aug. 16 1921

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56190

D 56190

105

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 Ogston ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Clark

(Residence in Baltimore: No. 414 Ogston St.; 42 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1917. (Year)

7-AGE, 4 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....none.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Black

11-BIRTHPLACE OF FATHER (State or Country), va

12-MAIDEN NAME OF MOTHER Ellen Cain

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Black

(Address) 414 Ogston St

15- AUG 16 1921 ROBERT J KRAUTER

Filed....., 191.... Registrar

Burial Permit

CAUSE OF DEATH to be plainly written, and all questions answered so far as known. Every question must be answered, or the certificate will be returned for correction. Use only black ink. Do not use pencil. Be particular to give full names of streets and numbers, and to fill in all dates. Every certificate must be signed by the physician, if there was one in attendance, and by the undertaker. Every certificate must be filed with the Registrar of the district in which the death occurred before a burial permit will be issued. Please write plainly and carefully, as illegible certificates cannot be accepted. Every statement is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 14 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 1921 to Aug 14 1921, that I saw h[er] alive on Aug 13 1921, and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Pleural Infection

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Osborn M. D.

8-16, 1921 (Address) 414 W Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Aug. 16, 1921.

20-UNDERTAKER Daniel Easter

ADDRESS 916 Ca ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56191

D 56191

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 755 W Franklin ST.; 17 WARD)

2-FULL NAME Mary Elizabeth Ireland

(a) RESIDENCE. NO. 755 W Franklin ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of June 12 - 1920

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Dugless

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Ireland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eliza Ireland
(Address) 755 W. Franklin St

15 Filed AUG 16 1921 19 [redacted] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1921, to Aug 15, 1921, that I last saw her alive on Aug 14 1921, and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

.....(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY
(Secondary) .....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 755 Franklin

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H Cleaver, M. D.

, 19 (Address) 753 Longe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
N.W. Auburn Cem	Aug 16 1921
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 56192

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

17 2d

D 56192

Registered No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3043 Belmont St.: 16 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ella Gambrill

(Residence in Baltimore: No. 3043 Belmont St.: 60 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Aug 16, 1861 (Month) (Day) (Year)

7 AGE: 60 yrs. 11 mos. 30 ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): do

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph J. Gambrill

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary J. Young

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary J. Gambrill

(Address) 3043 Belmont Av

15 Filed AUG 16 1921

ROBERT I KRAUTZ
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug 15, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to Aug 15 1921.
that I saw her alive on Aug 15, 1921.
and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:

Fracture in left femur (hip) due to accident. July 20 21 (Barr)

Hypostatic pneumonia (Duration) ..... yrs. ..... mos. 26 ds

Contributory (SECONDARY) acute dilatation of heart. (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) W. S. Niblett M. D.

Aug 15 21, 191.... (Address) 2220 Parkside Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL ~~OR REMOVAL~~: London Park — DATE OF BURIAL: Aug 17, 1921

20 UNDERTAKER: Geo W Little — ADDRESS: 2700 E Lmondson Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56193

CERTIFICATE OF DEATH.

28 D 56193

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 E. Randall St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Bradley

(a) RESIDENCE. No. 35 E. Randall St. ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James L. Bradley

6 DATE OF BIRTH (month, day, and year) Feb 23 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Winchester Md.

PARENTS

10 NAME OF FATHER J. Wesley Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Annie Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant James L. Bradley Jr.
(Address) 35 E. Randall

15 Filed ..... 19 ..... Registrar
A 0056193 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to Aug 14, 1921

that I last saw h alive on Aug 14, 1921

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Ephanchan

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. P. Campbell, M. D.

8/16 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	8/17 1921
20 UNDERTAKER	ADDRESS
J. Fen McCully	130 Court

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56194

CERTIFICATE OF DEATH.

120 D 56194

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1103 Dalton ST., 11 WARD)

2-FULL NAME Greg Wingate

(a) RESIDENCE NO. 1103 Dalton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matter Wingate

6 DATE OF BIRTH (month, day, and year) Unknown 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate 086

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer S. C.

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Matter Wingate

(Address) 1103 Dalton St

15 Filed AUG 16 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1921, to Aug. 13, 1921, that I last saw him alive on Aug 13, 1921, and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 2 mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) about yrs. 4 mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Templeman M. D.

8/15 1921 (Address) 1019 Dolphin Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Lawn	Aug 16, 1921
20 UNDERTAKER Daniel F. Hennessy	ADDRESS Mt Belle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56195

CERTIFICATE OF DEATH.

64 D 56195

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 W. Lombard ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie D. Trapp

(Residence in Baltimore: No. 1231 W. Lombard St.; 63 yrs. 4 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, April 5, 1858 (Month) (Day) (Year)

7-AGE, 63 yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto - Md

PARENTS.

10-NAME OF FATHER, Adam Popp

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward A. Trapp

(Address) 212 W. Pratt St.

15- Filed AUG 16 1921, 191..... ROBERT B. KRAUTER REGISTRAR

CAUSE OF DEATH to be plainly stated, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 14, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 11 1921, to Aug 14 1921, that I saw her alive on Aug 13 1921, and that death occurred, on the date stated above, at 8 A.M. The CAUSE OF DEATH* was as follows:

Recurrent Cerebral Hemmorrhage

(Duration) 1 yrs. 6 mos. 3 ds.

Hemiplegia & Chronic Arteris Sclerosis.

CONTRIBUTORY (Secondary) (Duration) Over 3 yrs. mos. ds.

(Signed) Geo. C. Ober M. D.

Aug 15, 1921. (Address) 1213 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Paul's New Cemetery Lane. DATE OF BURIAL, Aug 17th, 1921

20-UNDERTAKER J. Flanagan & Son ADDRESS 90 Hudson St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109 D 56196

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Daniel Sullivan

(a) RESIDENCE. NO. 1144 W. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? 51 yrs — mos — ds

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of each item is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 20, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Timothy Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Ortan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs S. E. Lockard
(Address) 1144 W Lombard St

15 Filed AUG 16 1921 ROBERT E. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1921, to Aug 14, 1921.

That I last saw him alive on Aug 14, 1921.

and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Dyspepsia

(duration) yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? Endowed Dist.

Did an operation precede death? Yes Date of July 26 1921

Was there an autopsy? No

What test confirmed diagnosis? Surgery

(Signed) John O'Connor M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Aug 17 1921

20 UNDERTAKER John J Cowan & Son

ADDRESS 901 Hollins St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56197

CERTIFICATE OF DEATH.

1915

D 56197

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3303 - Paine ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Marie Dammyer.

(Residence in Baltimore: No. 3303. Paine st. St.; yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Sept. (Month) 13. (Day), 1918. (Year)

7-AGE, 2 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto city Md.

PARENTS.

10-NAME OF FATHER Joseph H. Dammyer

11-BIRTHPLACE OF FATHER (State or Country) Balto city Md

12-MAIDEN NAME OF MOTHER Elsie E Welk

13-BIRTHPLACE OF MOTHER (State or Country) Balto city md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsie E. Dammyer

(Address) 3307 Paine St

15- ROBERT J. KRAUTER Registrar.

Filed AUG 16 1921 1921 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John H. Morrison M. D. (Coroner.)

Aug 15, 1921 (Address) 3632 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Marys Cemetery	Aug. 17, 1921
20-UNDERTAKER J. Walter Davis	ADDRESS 3303 Paine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 56198

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56198

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1101 Haubert Street. St.: 21st WARD)

REGISTERED No. C 150

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret J. Robinson.

(Residence in Baltimore: No. 1101 Haubert Street. St.: ---yrs., ---mos. ---ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single.

6-DATE OF BIRTH: August 15th. 1921., / (Month) (Day) (Year)

7-AGE: ---yrs. ---mos. ---ds.

If LESS than 1 day, 5 hrs. or --- min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 0
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: George W. Robinson.

11-BIRTHPLACE OF FATHER (State or Country): Baltimore Md.

12-MAIDEN NAME OF MOTHER: Freda L. Koehler.

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W. Robinson. (father).

(Address) 1101 Haubert Street.

15- Filed AUG 16 1921 ROBERT [illegible] Registrar. (Clerk)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 15th, 1921. 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. ...mos. ...ds.

I Signed Otto M. Pennartz M. D. (Coroner)

Aug. 16, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: St Pauls Cem.

DATE OF BURIAL: Aug 16 1921

20-UNDERTAKER: H. Lander & Sons

ADDRESS 1710 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56199

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N. Duncan ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Virginia

2-FULL NAME Lizzie Brown

(a) RESIDENCE. NO. 520 N. Duncan ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Brown.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic and Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer: Farmville Va

9 BIRTHPLACE (city or town) (State or country): Branch Scott Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Elizabeth Bedford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Sarah Venable (Address) 520 N. Duncan St

15 Filed AUG 16 1921 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 14 Aug 1921

17 I HEREBY CERTIFY, That I attended deceased from 13 Aug. 1921, to 14 Aug. 1921, that I last saw h[illegible] alive on 13 Aug. 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

about ½ day

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Respiratory failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 520 N. Duncan St

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Ellwood Field Boyle, M. D.

1921 (Address) 422 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Fort Hurs	Aug 16 1921
20 UNDERTAKER	ADDRESS
Wm J. G. Locke	1382 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56200

CERTIFICATE OF DEATH.

151

D 56200

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1632 Mc Henry St. St.: 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby O'Neill

(a) RESIDENCE. No. 1632 Mc Henry St. St.. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 16, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry G O Neill.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Teresa T Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry G O Neill
(Address) 1632 Mc Henry St.

15 AUG 16 1921 19 ROBERT I. KRAUTH Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1921, to Aug 15, 1921, that I last saw h alive on Aug 15, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. V. Cumberson, M. D.

8/16/21 (Address) 34 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 16 1921

20 UNDERTAKER Harry H. Witzke ADDRESS 1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spmc.—6-8-19—H. P. Co.—1000 Bks.

D 56201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56201

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 West Franklin ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Frey

(a) RESIDENCE. NO. 1310 West Franklin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J Frey

6 DATE OF BIRTH (month, day, and year) Feb. 14 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Broughton

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Miss Marsden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Mrs. L.R. Woollen

(Address) 1310 W. Franklin St.

15 Filed AUG 16 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 10 1921 to Aug 15 1921 that I last saw h[illegible] alive on Aug 15 1921 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Laryngis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Uremia - Pulmonary Edema (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

8/16 1921 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Aug 17 1921

20 UNDERTAKER Joseph L B Cook

ADDRESS 1003 W Balto St

MAILER should be carefully supplied. Exact statement of OCCUPATION may be properly classified, so that it may be properly coded. Write CAUSE OF DEATH in plain terms, so that it may be properly classified

Form—6-9-19—H. P. Co.—1000 Blks.

D 56202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 56202

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2507 Frances St. (St.) 13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Sharp

(a) RESIDENCE. NO. 2507 Frances St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State) Delaware

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. (if of foreign birth)? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John B. Sharp

6 DATE OF BIRTH (month, day, and year) Aug. 25th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Mr. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Pearl S. Bowen

(Address) 2507 Frances St.

15 Filed AUG 16 1921 19 ROBERT R. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1921 to Aug 14 1921.

that I last saw her alive on Aug 14 1921.

and that death occurred, on the date stated above, at 4.30 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of arm + Buttock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Lynch M. D.

8/18 1921 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hillsboro, Md. DATE OF BURIAL Aug 17 1921

20 UNDERTAKER Joseph L. Cook ADDRESS 1031 N. Eutaw St

IMPORTANT. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH may be necessary. See instructions on back of certificates. INFORMATION is very important.

Frank Rocy Petro

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56203 D 56203

CERTIFICATE OF DEATH.

REGISTERED NO. C

1 PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. St. Bats Hospital ST.; WARD)

2 FULL NAME Frank Rocy,

(Residence in Baltimore: No. Curtis Bay, (Camp) St.; yrs., mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, August 10th, 1920
(Month) (Day) (Year)

7-AGE, 1 yrs. — mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Lowell, Mass.

PARENTS.

10-NAME OF FATHER Frank Petro

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Helena Petra

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank R. Petro

(Address) Curtis Bay Camp

15- AUG 16 1921 ROBERT T KRAUTER
Filed....., 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, au(topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Accident
(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Shock,
(Duration) 2 yrs. mos. ....ds.

(Signed) E. C. Bladel M. D.
(Coroner)

8/13/21 191... (Address) 1436 Binney

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos. 21 ds. In the State....yrs....mos. 24 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincent Cem	8/16/21, 19....
20-UNDERTAKER Geo J Ruth	ADDRESS 1705 Hanford Ave.

N.B.—Every item of information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56204

CERTIFICATE OF DEATH.

8 D 56204

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 N. Mount ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Whalen

(a) RESIDENCE. NO. 1131 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Whalen

11 BIRTHPLACE OF FATHER (city or town) Providence
(State or country) R. I.

12 MAIDEN NAME OF MOTHER Anna Miller

13 BIRTHPLACE OF MOTHER (city or town) Chas. Co.
(State or country) Md.

14 Informant Mother (Anna Whalen)
(Address) 1131 N. Mount St.

15 Filed AUG 16 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-15- 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1921, to Aug. 15, 1921, that I last saw h[illegible] alive on Aug. 14, 1921, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 1727 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Aug 16 1921
20 UNDERTAKER Edward Ringgold	ADDRESS 1463 N. Gay St

IMPORTANT.—Information should be carefully supplied. Avoid abbreviations. Write it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56205

CERTIFICATE OF DEATH.

167

D 56205

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University of Md. 22nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane A. Johnson

(Residence in Baltimore: No. 602 S. Green St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	col'd	Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: no
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE (State or Country). Balto.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane A. Johnson

(Address)

15- Filed AUG 16 1921, 191.. ROBERT E KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 13, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns general (multiple) accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Aug 15, 1921 (Address) 1032 Lee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, Aug 17, 1921

20-UNDERTAKER Wm H. Cave Sons | ADDRESS 1400 Mosher

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56206

CERTIFICATE OF DEATH.

150
D 56206
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1414 Mosher St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Brooking

(Residence in Baltimore: No. 1414 Mosher St.: yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	single

6-DATE OF BIRTH, ... Aug. 13 ....., 1921
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
.....yrs.....mos....1....ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Chas. Stewart

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Harriett Brooking

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Stewart

(Address) 1414 Mosher St.

15-

ROBERT J. KRAUTER

Filed ..... 191..... (Clerk.)
AUG 16 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... August 14 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(Duration).....yrs.....mos. 1 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Aug 14, 1921 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Ft. Hudgins	Aug 16 19 21
20-UNDERTAKER	ADDRESS
Wm. H. Clasen & Co.	1301 Mosher St.

*Item of information should be carefully supplied. Accuracy in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-13—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56207

63-0210 56207

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital STREET OR WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Sussman

(a) RESIDENCE. NO. 20 S. ann ST., WARD. Life

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Abraham Sussman

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Cecelia Kaplan

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Jack Lewis
(Address) 1811 E Balto St

15 FILED AUG 16 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clock

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1921, to Aug 16, 1921, that I last saw him alive on Aug 16, 1921, and that death occurred, on the date stated above, at 6:20 a m.

The CAUSE OF DEATH* was as follows:

Poliomyelitis
(Bulbo-spinal)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. Blackman, M. D.

8/16/21 (Address) Sydenham Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	8/16 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1811 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

151 ✓ D 56208

REGISTERED No. C .....

1 PLACE OF DEATH D 56208

CITY OF BALTIMORE (No. 3244 Barclay st ST.: 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and nomber and fill out No. 18.)

2 FULL NAME Baby Johnson

(Residence in Baltimore: No. 3244 Barclay st. St.: 5 mo. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: f.

4 COLOR OR RACE: colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6 DATE OF BIRTH: aug 14, 1921 (Month) (Day) (Year)

7 AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or 1 min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: ——— Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Samuel Johnson

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Jane Waters

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H Pfluthelm

(Address) 632 Gorsuch ave.

15. Filed AUG 16 1921, 191 ROBERT J. KRAUTER Registrar of Vital Statistics REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: aug 14, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 14, 1921, to aug 14 1921, that I saw h— alive on aug 14, 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

5 months marasmus

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Pfluthelm M. D.

aug 14, 1921 (Address) 632 Gorsuch ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191....

20 UNDERTAKER | ADDRESS

Johns Hopkins Hospital Commissioner Health AUG 17 1921

D 56209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 56209

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. So. Balto Hospital St. [illegible] WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aloysious Williams

(Residence in Baltimore: No. 1 W. Base St St.; yrs. [illegible] mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	Co	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE 23 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer. O&D
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). W. I. Islands

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- AUG 16 1921
Filed ....., 191.... ROBERT B KRAUTER
Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound accidental

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Kicks

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Blandy M. D.
(Coroner)

(Address) 1431 Gray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
PUBLIC CEMETERY	....., 19....
20-UNDERTAKER	ADDRESS
Commissioner Health.	AUG 17 1921

Wm E WOODALL

N. B.—Every item of information should be carefully supplied. AGE in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56210

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56210

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3216 Colgate ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar J. Otto

(a) RESIDENCE. No. 3216 Colgate ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Jennie Otto

6 DATE OF BIRTH (month, day, and year) Dec. 21st 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm Otto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anna M. Nelson (Address) 2029 E. Biddle

15 Filed , 19 Robert P. Harrison, Registrar

AUG 16 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15th 1921

17

I HEREBY CERTIFY, That I attended deceased from August 1, 1921, to August 15, 1921, that I last saw him alive on August 15, 1921, and that death occurred, on the date stated above, at 6 30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? From wife.

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Presence of Bacillus

(Signed) Allen C. Beetham, M. D.

8-16, 1921 (Address) 3139 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 19 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56211

HEALTH DEPARTMENT—CITY OF BALTIMORE

42

D 56211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3503 Leverton Ave. N WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Benny

(a) RESIDENCE. No 3503 Leverton Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs 6 mos. 20 ds. How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): White

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. L. Benny

6 DATE OF BIRTH (month, day, and year): Dec. 26 72

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Wm. L. Benny 3503 Leverton Ave.

15 Filed AUG 6 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1921, to Aug 15th 1921, that I last saw her alive on Aug 14th 1921, and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Carcinoma of Stomach

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Snyder M. D.

8/16 19 (Address) 3523 Bell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr. Carmel Cem	Aug 18 19 21
20 UNDERTAKER	ADDRESS
Philip Henig	2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56212

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2313 Edgemont Ave. (St.) 13 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence May Mitchell

(a) RESIDENCE. No. 2313 Edgemont Ave. St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Robert C. Mitchell

6 DATE OF BIRTH (month, day, and year) June 22 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Charles Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Sarah Shaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Carrie Landis (Address) 1616 N. Payson St.

15 Filed AUG 16 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Apl. 1 1921, to Aug. 16, 1921, that I last saw her alive on Aug. 13, 1921, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Liver

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no over

What test confirmed diagnosis? no

(Signed) Herbert C. Blake, M. D.

, 19 (Address) 1014 N. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 18 1921
20 UNDERTAKER	ADDRESS 1944
Harry W. Ehlen	N. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Birchett)

D 56213

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 56213

CERTIFICATE OF DEATH

79

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2439 Edmondson Av ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert D. Birchett,

(Residence in Baltimore: No. 2439 Edmondson Av St.; 24 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Feb. (Month) 26 (Day), 1896 (Year)

7-AGE: 24 yrs 7 mos 26 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Nothing
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto. Md

PARENTS

10-NAME OF FATHER: Richard T. Birchett

11-BIRTHPLACE OF FATHER (State or country): Balto. Md

12-MAIDEN NAME OF MOTHER: Katherine Mason

13-BIRTHPLACE OF MOTHER (State or country): Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Getz, M.D.

(Address) 1111 W. Lanvale St.

15- Robert P. Harrison,

Filed ..... 191 ..... Burial Permit Clerk. REGISTRAR

AUG 16 1921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: August (Month) 16th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14th, 1921, to, Aug 16th 1921, that I saw him alive on Aug 16th 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of the Heart.

(Duration) 11 yrs — mos. — ds.

Contributory (SECONDARY) Chronic Parenchymatous Nephritis

(Duration) — yrs 6 mos. — ds.

(Signed), Chas. Getz, M. D. M. D.

Aug 16th, 1921. [Address] 1111 W. Lanvale St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge

DATE OF BURIAL: Aug 18, 1921

20-UNDERTAKER: Geo W Little

ADDRESS: 3708 Edmondson Av.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56214

CERTIFICATE OF DEATH.

64 D 56214

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 534 N arlington ave. St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sue L Stark

(Residence in Baltimore: No. 534 N. Arlington St.: 70 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 21, 1850 (Month) (Day) (Year)

7-AGE, 70 yrs. 10 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stoner W'd
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Stark

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Katherine Kreglo

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. W. Bennett

(Address) 534 Arlington Av

15- AUG 16 1921

Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 16, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 — 1921, to Aug. 16 1921, that I saw her alive on Aug. 16 1921, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy Right

Hemiplegia (Duration) 1 mos. 6 wks ds.

CONTRIBUTORY (Secondary) Senility (Duration) — yrs. — mos. — ds.

(Signed) Charles M. Carr M. D.

Aug. 16., 1921. (Address) 1127 W Lombard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, Aug. 18 1921

20-UNDERTAKER Sue W Little — ADDRESS 2700 Edmondson Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

James E. Parren.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 ✓ D 56215

D 56215

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 McDonough ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edward Parren

(a) RESIDENCE. NO. 810 McDonough ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	Colored	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Percy Parren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER adell williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Percy Parren 810 McDonaughs

15 Filed AUG 17 1921 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-15-1921

17 I HEREBY CERTIFY, That I attended deceased from 8-14-, 1921, to 8-15-, 1921, that I last saw h alive on 8-15-, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Parents (duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Bargill, M. D.

8-15, 1921 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	8/17/21

20 UNDERTAKER Leo Cook ADDRESS 1906 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56216

CERTIFICATE OF DEATH.

40 D 56216

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Church Home and Infirmary St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry G Martin

(a) RESIDENCE. NO. 103 West Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a If ~~married~~, widowed, or ~~divorced~~
HUSBAND of
(or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) Dec 6. 1856

7 AGE	64 Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER G H Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cuba

12 MAIDEN NAME OF MOTHER Mary Cuslett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) John G Martin 103 W Monument St

15 Filed AUG 17 1921 ROBERT J KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 16 1921

17 I HEREBY CERTIFY, That I attended deceased from August 9, 1921, to August 16, 1921, that I last saw him alive on August 16, 1921, and that death occurred, on the date stated above, at 4.55 a.m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) H. D. Noble - M. D.

. 19 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Aug 17 1921
20 UNDERTAKER	ADDRESS
Henry H Jenkins & Son Co	Oakland Ave - Catonsville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Shaved.
Autopsy, Liver, Intestines
Heart, Bladder + Skin
involved.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56217

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Juliana McCann

(a) RESIDENCE. No. Mount Hope Retreat ST., 28 WARD. (Portland Me.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 0 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	69	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious Sister of Mercy

(b) General nature of industry, business, or establishment in which employed (or employer) Religious Work D65

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Portland Maine.

PARENTS

10 NAME OF FATHER John McCann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portland Me

12 MAIDEN NAME OF MOTHER Ann Haggerty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portland Maine.

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md.

15 Filed AUG 17 1921 ROBERT I. KRAUTER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16th 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr 20th, 1920, to Aug 16th, 1921,

that I last saw her alive on Aug 16th, 1921,

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis cerebral

abt (duration) 7 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Mania Senile

abt (duration) 7 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Portland Maine.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Aug 16th, 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Portland Maine	Aug 19 1921
20 UNDERTAKER [illegible] COMPANY (Address) [illegible] Successor	ADDRESS [illegible] W. SOUTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56218

CERTIFICATE OF DEATH.

D 56218

42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Kroll

(a) RESIDENCE. NO. 422 S. Furrow St ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

37

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed AUG 17 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 16 1921

17 I HEREBY CERTIFY, That I attended deceased from August 12, 1921, to August 16, 1921, that I last saw her alive on August 15, 1921, and that death occurred, on the date stated above, at 12:15 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia.

Unknown. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of No

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) L. P. Broadfoot, M. D.

8/16/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 20 1921
20 UNDERTAKER	ADDRESS
William H. Shriver	1016 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. F. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56219

CERTIFICATE OF DEATH.

28 D 56219

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 N. Eden ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Boettinger

(a) RESIDENCE. No. 1207 N. Eden ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary L. Boettinger

6 DATE OF BIRTH (month, day, and year) Dec. 21st 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

038

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo. Boettinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary L. Boettinger

(Address) 1207 N. Eden

15 Filed AUG 17 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from October, 1919, to Aug. 14, 1921, that I last saw h[illegible] alive on Aug. 14 1921, and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

General Tuberculosis
Pulmonary Fibroid

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of October 1919

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. H. Hartman, M. D.

Aug 16 1921 (Address) 221 W. Monument St. City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem.	Aug 17 1921
20 UNDERTAKER	ADDRESS
Philip Herrig	Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Hudson.

1499 9/9 56220 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56220

CERTIFICATE OF DEATH. X 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Douglass

(a) RESIDENCE NO. Loch Raven Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Margaret Parks

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Johns Hopkins Hospital Records.
(Address)

15 Filed AUG 17 1921, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 16 1921

17 I HEREBY CERTIFY, That I attended deceased from August 4, 1921, to August 16, 1921, that I last saw her alive on August 15, 1921, and that death occurred, on the date stated above, at 6.55 A. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Aug 13, 1921

Was there an autopsy? Yes Ventriculography.

What test confirmed diagnosis? Gross Pathology.

(Signed) Harry G. Wahl, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ivy Marie Towson	Aug 17 1921
20 UNDERTAKER John Burns Sons	ADDRESS Towson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary Cause Unknown

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56221

CERTIFICATE OF DEATH.

170 D 56221

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Eutaw Place ST.; 14 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James William Dew

(Residence in Baltimore: No. 1604 Eutaw Place St.; 8 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, January 14, 1851.
(Month) (Day) (Year)

7-AGE, 70 yrs. 7 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Confectioner & Grocer

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George Robt Dew

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Mary Cromwell

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. James Dew

(Address) 1604 Eutaw Place

15- Filed AUG 17 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1919, to Aug 14 1921, that I saw him alive on Aug 14 1921, and that death occurred, on the date stated above, at 10.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Ernest Rahe M. D.

Aug 18, 1921 (Address) 910 N. Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral DATE OF BURIAL, Aug 18, 1921

20-UNDERTAKER H. M. Caulfield ADDRESS 2839 Gwynn Oak Ave Balto Md

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56222

CERTIFICATE OF DEATH.

134

D 56222

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1264 Battery Ave ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Felica~~ Rhea Beveridge

(a) RESIDENCE. No. 1264 Battery Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs 11 mos 15 ds How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr George W. Beveridge

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ernest J. Rhea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Blanch Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant George W. Beveridge (Address) 1264 Battery ave

15 AUG 17 1921 ROBERT J. KRAUTH Registrar

Burial to be strictly supplied. Are Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1921, to Aug 15, 1921, that I last saw h er alive on Aug 15, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. 6 mos. — ds

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. 7 mos. 5 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 8/21

Was there an autopsy? No

What test confirmed diagnosis? Blood & Stools

(Signed) A. Hunt Feldman M. D.

. 19 (Address) 1340 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug 18, 1921
20 UNDERTAKER George J. Smith	ADDRESS 1900 W Fayette St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56223

CERTIFICATE OF DEATH.

159 D 56223

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 507 S. Linwood Ave ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George J. Smith

(Residence in Baltimore: No. 507 S. Linwood Ave. St.; yrs., 57 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1864 (Year)

7-AGE,	If LESS than 1 day,
57 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). City

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Smith

(Address) 507 S Linwood Ave

15-

Filed AUG 17 1921 191 ROBERT J. BEAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 15/21 (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said invest (Inquest, autopsy or inquiry.) igation find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicde by shooting self with revolver

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Ryan Coroner M. D.

Aug 17 1921 (Address) Woody Rhodes

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Trinity Cem	Aug. 18. 1921
20-UNDERTAKER	ADDRESS
Peter Nicolaus	2041 Eastern

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 56224

HEALTH DEPARTMENT—CITY OF BALTIMORE

166

D 56224

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1101 North Stricker St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs E. L. Saxo

(Residence in Baltimore: No. 1101 North Stricker St.; 68 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, June (Month) 4 (Day), 1843 (Year)

7-AGE, 78 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): " "

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) V. Elsa Saxo

(Address) 1101 N Stricker

15-

AUG 17 1921

Filed ....., 191.....

ROBERT J. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...August (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Stomach.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) J. Lee Hoffman M. D. (Coroner.)

Aug 17, 1921 (Address) 3632 Reisterstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn — DATE OF BURIAL, Aug 19, 1921

20-UNDERTAKER, Wm Frankforth — ADDRESS 1618 Eastern

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56225

CERTIFICATE OF DEATH.

159 D 56225

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1101 - N. Stricker ST.: 16 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward. Saro

(Residence in Baltimore: No. 1101 - N. Stricker St.: Life yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept (Month) 12 (Day), 1884 (Year)

7-AGE, 36 yrs. 11 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Q&O

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, W. E. Saro

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ida M. Bernhard

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victor Saro

(Address) 1101 N. Strieker

15- AUG 17 1921 ROBERT J. KRAUTER Registrar

Filed ....., 191... .....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained at said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun Shot wound through r. temple head

Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Morrissey M. D. (Coroner.)

Aug 15 1921 (Address) 3632 Roslyn Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cat Lawn	Aug 17 1921
UNDERTAKER	ADDRESS
Wm Faulkner & Co	168 East

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56226

CERTIFICATE OF DEATH.

28 D 56226

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 S. Robinson ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodor H. E. Lingerman

(a) RESIDENCE NO. 617 S. Robinson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Lingerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Lingerman
(Address) 718 S. Robinson St

15 Filed AUG 17 1921, 19 ... ROBERT J. KRAUTER Registrar
Daniel Powell Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to Aug 15, 1921, that I last saw h in alive on Aug 14, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 6 mos ds.

CONTRIBUTORY .....
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) W. J. McAneny, M. D.

Aug 6 1921 (Address) 839 S. Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Aug. 18 1921

20 UNDERTAKER Levy & Fuller

ADDRESS 1038 Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56227

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56227

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 345 S. Fulton Ave. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Franklin Kerr Jr.

(a) RESIDENCE. No. 345 S. Fulton Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 5th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Franklin Kerr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Martinsburg W. Va.

12 MAIDEN NAME OF MOTHER: Elizabeth Bosley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Charles Franklin Kerr

(Address): 345 S. Fulton Ave.

15 Filed AUG 17 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15th. 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 . 1921 . to Aug 16 . 1921 .

that I last saw him alive on Aug 16 . 1921 .

and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Hurtham Enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Walter Dent, M. D.

8/18/21 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery.	Aug 17 "21

20 UNDERTAKER: Joseph L. B. Cook. ADDRESS 1003 W. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Wodka)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56228

CERTIFICATE OF DEATH.

105 D 56228

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1606 Aliceanna St. V WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Wodka

(Residence in Baltimore: No. 1606 Aliceanna St. St.: yrs., 5 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 5 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dependent
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, John Wodka

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Anna Kunck

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M Wodka

(Address) 1606 Aliceanna St

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 16, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pleuro Enteritis

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner.)

Aug 17, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Aug 18 1921

20-UNDERTAKER John M Weber

ADDRESS 1803 Bank St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56229

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D 56229

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mohammed Alli

(a) RESIDENCE. No. 1615 Lemmon st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Egyptian / Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Egypt

PARENTS

10 NAME OF FATHER ? Alli

11 BIRTHPLACE OF FATHER (city or town) (State or country): Egypt

12 MAIDEN NAME OF MOTHER Marrine Alli

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Egypt

14 Informant: Hospital Records

(Address) M.T.H.

15 Filed . 19 ROBERT I. KRAUTER Registrar

AUG 17 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 18 1921 to Aug. 14 1921

that I last saw him alive on Aug. 14 1921

and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalrymple M. D.

8-18-21. 19 (Address) Municipal Tbc Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: AUG 17 1921 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

Per. Wm. F. WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

148994 D 56230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 D 56230

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 5 WARD)

2-FULL NAME William Gordon

(a) RESIDENCE NO. 1230 E. Lexington St. Bost St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13. 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief

(b) General nature of industry, business, or establishment in which employed (or employer) Hdd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 2.

PARENTS

10 NAME OF FATHER 2.

11 BIRTHPLACE OF FATHER (city or town) (State or country) 2.

12 MAIDEN NAME OF MOTHER 2.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) 2.

14 Informant Johns Hopkins Hospital
(Address)

15 Filed AUG 17 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to Aug 9, 1921,

that I last saw him alive on Aug 9, 1921,

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Bacillary dysentery (Flexner)

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool Culture

(Signed) W R Dawson, M. D.

Aug 10 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS AUG 17 1921

Record

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56231

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2427 E. Preston ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara V. Rutter

(a) RESIDENCE. No. 2427 E. Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, ~~divorced~~
(or) WIFE of Richard T. Rutter

6 DATE OF BIRTH (month, day, and year) Oct 18, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	9	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) 03
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Aaron Stockton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary E. Leary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Richard T. Rutter
(Address) 2417 E. Preston

15 Filed Aug. 19, 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Aug 16, 1921,
that I last saw h. alive on Aug 16, 1921,
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Mitral Stenosis (duration) 15 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. E. Hoches, M. D.

(Address) 1301 N Pat Rank

Aug 19 21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Aug 19 192
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

AUG 19 1921

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56232

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56232

CERTIFICATE OF DEATH.

76

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; 1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John S. Broome

(a) RESIDENCE. No. 4248 Pattison Park Ave Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901, July 25

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Automobile accessories

(c) Name of employer J. S. Bloom Co

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER John S. Broome.

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Peterson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant University Hospital
(Address)

15 Filed ....., 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1921, to Aug 16, 1921,

that I last saw him alive on Aug 16, 1921,

and that death occurred, on the date stated above, at 8 PM m.

The CAUSE OF DEATH* was as follows:

Septic Meningitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Otitis Media

(duration) ..... yrs. 1 mos. 11 ds.

18 Where was disease contracted if not at place of death? 4248 S. Pattison Park Ave

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & Symptoms

(Signed) H B Jones, M. D.

Aug 16 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Aug 20 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56233

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 N Carrollton Ave St.; 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Artman

(Residence in Baltimore: No. 324 N Carrollton Ave St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March 6, 1864
(Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jeremiah J Artman

11-BIRTHPLACE OF FATHER (State or Country), U.S.

12-MAIDEN NAME OF MOTHER Louisa Hochst

13-BIRTHPLACE OF MOTHER (State or Country), U.S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adelia Artman

(Address) 324 N Carrollton

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

G 171921 [Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 29 1920, to Aug 15 1921, that I saw h[illegible] alive on Aug 15 1921, and that death occurred, on the date stated above, at 1.45 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

3 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas F. Blake M. D.

Aug 15, 1921 (Address) 1 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Aug 18, 1921

20-UNDERTAKER H C Brauning Son — ADDRESS 517 N. Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

D 56234

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56234

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Madison Ave St. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Belt.

(a) RESIDENCE NO. 919 Madison Ave

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. WARD

How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elk Ridge, Md.

PARENTS

10 NAME OF FATHER Otho Belt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER A. Belle Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Miss Belt

(Address) 919 Madison Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

G 1 71921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1921, to August 15, 1921.

that I last saw h alive on August 15, 1921.

and that death occurred, on the date stated above, at 9.18 m.

The CAUSE OF DEATH* was as follows:

Uterine prostration

(duration) — yrs. — mos 14 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Mary Mead Dean M. D.

, 19 (Address) 901 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 8/18 19 21

20 UNDERTAKER Chas. D. Evans & Son — ADDRESS 118 W. Mt. Royal Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56235

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56235

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Vincent asylum ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Doherty

(a) RESIDENCE. No. St Vincent asylum ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nn

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Doherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Laretta McGee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) St Vincent Asylum 501 Dunsan

15 Filed AUG 17 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1921

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1921, to Aug 16, 1921, that I last saw her alive on Aug 16, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? nn Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas F Clautice M. D.

(Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	8/17 1921
20 UNDERTAKER	ADDRESS
Jno. J. Bigman & Sons	1009 E. Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 17 1921 Burial Permit Clerk. Asst. Registrar. Issued

D 56236 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56236

CERTIFICATE OF DEATH 159 REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. South Bend Ave. South Road Mt Washington ST.: 27 WARD)
2-FULL NAME Meyer Benjamin Goldsmith
(Residence in Baltimore: No. Mt Washington St.: yrs., mos., ds.)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. July (Month) 24th (Day), 1862 (Year)

7-AGE. 59 yrs. 22 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: clothing
(b) General nature of industry, business, or establishment in which employed (or employer): mfg

9-BIRTHPLACE (State or Country): Balto Md

PARENTS.
10-NAME OF FATHER: Simon Goldsmith
11-BIRTHPLACE OF FATHER (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Regina Landheimer
13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.
(Informant) S. Goldsmith
(Address) Mt Washington

15-
Filed ....., 191.... Registrar.
Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and from information received from Medical (Medical autopsy or inquiry) find that said deceased came to Medical death on the day stated above.

The CAUSE OF DEATH* was as follows:
Gun Shot wound through his head (Suicide)
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) John J. Morrissey M. D. (Coroner)
Aug 17 1921 (Address) 3632 Roland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. London Park DATE OF BURIAL. Aug 18 1921

20-UNDERTAKER David Sondheim ADDRESS 18 Eutaw

EB.- Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UG 17 1921

(Maude Holcomb)

Spec.—1-10-21—M&T—1500 Bks.

149744

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56237

D 56237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Maude Holcomb.

(a) RESIDENCE NO. Fenwick, W Va. ST., WARD Fenwick W. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 17 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Holcomb. (Husband)

6 DATE OF BIRTH (month, day, and year): Jan. 6, 1880.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: W Wife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): W Va

PARENTS

10 NAME OF FATHER: Joe Fellard.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio.

12 MAIDEN NAME OF MOTHER: Mary Morris.

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Johns Hopkins Hospital. Records

~~Robert F. Barrows~~

15 AUG 17 1921 .19 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 14, 1921

17

I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to Aug 14, 1921, that I last saw her alive on Aug 14, 1921, and that death occurred, on the date stated above, at 8, A m.

The CAUSE OF DEATH* was as follows:

Shock following operation on brain—

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary): Acromegly. Brain tumor(?)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 14

Was there an autopsy? Yes

What test confirmed diagnosis? Examination

(Signed) C. S. Coleman M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bowers W Va — DATE OF BURIAL: 8/17/21 19

20 UNDERTAKER: H E Hughes — ADDRESS: 411 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56238

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 64

CITY OF BALTIMORE: (No. 706 Aisquith St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Becker

(a) RESIDENCE. NO. 706 Aisquith ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~WIFE of~~ Emma Becker

6 DATE OF BIRTH (month, day, and year) Jan. 8th 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

088

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Elizabeth Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Becker
(Address) 706 Aisquith St

15 Filed AUG 18 1921 ROBERT J. TRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1921, to Aug 17, 1921, that I saw him alive on Aug 17, 1921, and that death occurred, on the date stated above, at 12 a. m.

The CAUSE OF DEATH* was as follows:

General arterial sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) 1 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. L. Hornstein, M. D.

8/17/21 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 20th 1921
20 UNDERTAKER	ADDRESS
General Cabaliers Home	1120 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56239

CERTIFICATE OF DEATH.

D 56239

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 E. Chase. St. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George. J. Thaler

(a) RESIDENCE. NO. 1422 E. Chase St. ST.. 10 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Mary.L.Thaler

6 DATE OF BIRTH (month, day, and year) May.20.1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stove & Plumbing bussiness

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Lorenz. Thaler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret.Hoffmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Thomas. Thaler

(Address) 1422 E. Chase St.

15 Filed AUG 18 1921 ROBERT I. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17. 1921

17 I HEREBY CERTIFY, That I attended deceased from 11 Aug. 19 21, to Aug 17. 19 21.

that I last saw h[illegible] alive on Aug 17 19 21.

and that death occurred, on the date stated above, at 5 P.M. m.

The CAUSE OF DEATH* was as follows:

Valv. Ds. heart.

~~Angina Pectoris~~

Ernst Rheu (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

Chron Int Nep (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. A. Foley, M. D.

(Address) 632 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug. 20. 1921

20 UNDERTAKER Henry Hoeck Son ADDRESS 1301 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 56240

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 St Paul ST.; 17 WARD)

2-FULL NAME Charles D Frith

(a) RESIDENCE. NO. 1613 St Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth 20 yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Wht	Married

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Emily S Frith

6 DATE OF BIRTH (month, day, and year) June 18/1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Accountant
(b) General nature of industry, business, or establishment in which employed (or employer) Edgewood Arsenal
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Henry G Frith

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sybella McCarthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Emily S Frith
(Address) 1613 St. Paul St

15 DATE RECEIVED AUG 18 1921 ROBERT J. BRAUER Registrar

Dr Stevenson 2221 Lafayette Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 15 1921

17 I HEREBY CERTIFY, That I attended deceased from August 12 1921. to August 15. 1921.
that I last saw him alive on August 15. 1921.
and that death occurred, on the date stated above, at 7.15 p. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. M. Harrison, M. D.

8/16. 1921 (Address) 10 rr West Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug. 17 1921
20 UNDERTAKER	ADDRESS
Wm Cals	826 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Robert W Franklin

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56241

CERTIFICATE OF DEATH.

D 56241

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 788 Sarah Ann ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert W Franklin

(Residence in Baltimore: No. 788 Sarah Ann St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, August 23, 1871 (Month) (Day) (Year)

7-AGE, 49 yrs. 11 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert Franklin

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Elizabeth Franklin

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Franklin

(Address) 788 Sarah Ann St

15- ROBERT B KRAUTER

Filed AUG 18 1921 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 15, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1* 1921, to Aug 15 1921, that I saw h— alive on Aug 15 1921, and that death occurred, on the date stated above, at 10½ m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) Ds Alcoholism

(Duration) ....yrs. ....mos. 15 ds.

(Signed) A K Foran M. D.

Aug 17, 1921 (Address) 702 S Bond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, Aug 18, 1921

20-UNDERTAKER Jas. H. Lucas — ADDRESS 1303 Fremont Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 56242

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1724 Harford ave (St.): 9 (Ward)

2-FULL NAME Annie A Wallace

(a) RESIDENCE. No. 1724 Harford ave (St.): ... WARD. ...

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Edward Wallace.

6 DATE OF BIRTH (month, day, and year) Aug. 2, 1859

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	62	-	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas McShane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER M. McShane. 8-1-[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Thomas Wallace. (Address) 1724 Harford ave

15 Filed AUG 18 1927 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1921, to Aug. 16, 1927, that I last saw her alive on Aug. 16, 1927, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) J. E. Runtagh M. D.

19 (Address) 1531 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug. 19 1927

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56243

D 56243

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wenger

(a) RESIDENCE. NO. 616 S. 12th St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Wenger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed . 19 ROBERT I. [illegible] Registrar

AUG 18 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 16 1921 to Aug 17 1921

that I last saw h[illegible] alive on Aug 17 1921

and that death occurred, on the date stated above, at 8 39 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray

(Signed) W. E. Davison, M. D.

, 19 (Address) J H H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	aug 18 1921
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 N Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1673 56244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 150 D 56244

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Smith

(a) RESIDENCE NO. Buffalo, N. Y. ST., ... WARD Buffalo N.Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3-1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) New York
(State or country)

12 MAIDEN NAME OF MOTHER Anna Conley

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed AUG 18 1921 ROBERT I KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17- 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 13 —, 1921. to Aug 17 —, 1921,
that I last saw h— alive on Aug 17 —, 1921,
and that death occurred, on the date stated above, at 4.35 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus
Meningocele

(duration) 4 yrs. 8 mos 14 ds.

CONTRIBUTORY (Secondary) Operative Shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 8-17-21

Was there an autopsy? Yes

What test confirmed diagnosis? Operation. X-Ray Examination of brain

(Signed) Emile Holman, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Buffalo N Y

DATE OF BURIAL aug 18 1921

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 Broadway

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Lewlein Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

56245

CERTIFICATE OF DEATH.

18 V D 56245

1 PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. Shelles Place near Biddle St. 16 WARD)

2-FULL NAME Seurlein Smith

(Residence in Baltimore: No. 1100 Mount st St.; yrs., mos. ds.)

REGISTERED No. C

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, C.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Tailor (b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Isaac Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rosa Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Smith

(Address) Lancaster Pa

15- AUG 18 1921 Filed ....., 191... ROBERT I. KRAUTER Registrar. Burial permit issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 14, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Gun Shot wound in head Homicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) John Harriss M. D. (Coroner.)

Aug 18, 1921 (Address) 3632 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, White Stone Hart. DATE OF BURIAL, Aug 18, 1921

20-UNDERTAKER Lancaster & Co ADDRESS 1463 W. Lanv St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Thomas

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56246

CERTIFICATE OF DEATH.

28 D 56246

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pier 4 Pratt St. ST. 3 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Thomas

(Residence in Baltimore: No. 246 S Sharp St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	Col.	?

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 50 70 years ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 0 87
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or Country).

PARENTS.

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Mrs Frank Thomas

(Address) .....

15- Filed AUG 18 1921 191.. ROBERT I KRAUSE Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug ..... 9 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... M Enquiry ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... M Enquiry ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Pulmonic tuberculosis .....

..... 1 ..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Hemorrhage .....

..... Pulmonic ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Daly ..... M. D.
(Coroner)

Aug 10, 1921 (Address) 1054 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND
AUG 1 1921

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Morgue

Spec.—6-9-19—H. P. Co.—1000 Bks.

D56247

HEALTH DEPARTMENT—CITY OF BALTIMORE

D56247

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 Hampson St. 13 37 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza A. Brown

(a) RESIDENCE. No. 806 Hampson ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dennis Brown

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balts. Co.

PARENTS

10 NAME OF FATHER Samuel Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriett Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Dennis Brown (Address) 806 Hampson St.

15 Filed AUG 18 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug-10, 1921, to Aug - 15, 1921, that I last saw h.. alive on Aug 14, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Hemeplegia (Left Side)

(duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? 1549 Lorman st, Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 1702 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Aug 18 21

20 UNDERTAKER [illegible] ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lucetic

Spec.—6-9-19—H. F. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56248

CERTIFICATE OF DEATH.

4 + 186

D 56248

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Findley

(a) RESIDENCE. NO. Delta Pa. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Cumberland Tel & Telegraph Co.

9 BIRTHPLACE (city or town) Delaware
(State or country)

PARENTS

10 NAME OF FATHER Newton Findley

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Hettie Caulford.

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Newton Findley
(Address) Delta Pa.

15 Filed AUG 18 1921 MOLLY I KRAUTER Registrar

Burial form all right

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1921, to Aug 17, 1921, that I last saw h.. alive on Aug 17, 1921, and that death occurred, on the date stated above, at 10:12 P. m.

The CAUSE OF DEATH* was as follows:

Fracture of 5th Cervical vertebrae.
Laminectomy was performed 8-16-21
Cause to follow is a Injury Sustained in
Accident on Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema (duration) yrs. Few hours mon. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Yes Date of Aug 16, 1921

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) George E. W. Hardy M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Delta Penna	Aug 18 1921
20 UNDERTAKER Williams Cook	ADDRESS 502 E Main

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56249

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 56249

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Olive St., Curtis Bay St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Louise Marcus

(a) RESIDENCE. No. 1 Olive St., St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 15th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Curtis Bay
(State or country) Md

PARENTS

10 NAME OF FATHER John Martin Marcus

11 BIRTHPLACE OF FATHER (city or town) Richmond
(State or country) Va.

12 MAIDEN NAME OF MOTHER Marjorie Olive Buhrman

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co
(State or country) Md

14 Informant John Martin Marcus
(Address) 1 Olive St - Curtis Bay

15 Filed AUG 18 1921 Albert I Krauter Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1921, to Aug. 17th, 1921, that I last saw her alive on Aug. 16th, 1921, and that death occurred, on the date stated above, at 8:45 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth
(about 7th mo)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY —
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo B Davis, M. D.

8/18, 1921 (Address) 211 Church St - Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	Aug 18 1921
20 UNDERTAKER	ADDRESS
Curtis Bay Funeral Home	916 Cortland

Information should be carefully supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56250

CERTIFICATE OF DEATH.

X #5 D 56250

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A Kelly Hospital St. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chandler Robbins (Robbins)

(a) RESIDENCE. No. Springfield, Ohio ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Feb 2nd 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Chandler Robbins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary S Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant G. N. Cromwell

(Address) Howard A. Kelly Hospital

15 AUG 18 1921 [illegible] Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 11, 1921, to Aug 18, 1921, that I last saw h[illegible] alive on Aug 18 1921, and that death occurred, on the date stated above, at 7.25 P. M.

The CAUSE OF DEATH* was as follows:

Post operative thrombosis & Pulmonary Embolism following excision of carcinoma of penis (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 12, 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy N. Cromwell M. D.

Aug 19, 1921 (Address) Howard A Kelly Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Springfield Ohio	August 18 1921
20 UNDERTAKER	ADDRESS
Henry H Jenkins Son Co	Exclusive Agts Ohio

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56251

CERTIFICATE OF DEATH.

D 56251

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: V Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia Herman

(a) RESIDENCE. No. 2017 E Pratt St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31 - 1920

7 AGE: 1 Years; Months; 18 Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Harry Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Romania

12 MAIDEN NAME OF MOTHER: Ida E. Chomsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed AUG 18 1921 19 ROBERT J. KRAUTER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 11 - 1921, to Aug 17 - 1921, that I last saw her alive on Aug 17 - 1921, and that death occurred, on the date stated above, at 11 00 P. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery (Flexner)

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Stool Cultures

(Signed) [illegible] M. D.

. 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Int Carmel

DATE OF BURIAL: 8/18 19[illegible]

20 UNDERTAKER: Jack Lewis

ADDRESS: 1441 E Baltimore St

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+79

D 56252

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Hospital for Women of Maryland ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Nettie Vandevender

(Residence in Baltimore: No. Hospital for Women of Maryland St.; ..... yrs., ... mos. 10 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	married

6-DATE OF BIRTH, ... 4 (Month) ..... 9 (Day), 1881 (Year)

7-AGE,	yrs.	mos.	ds.	If LESS than 1 day,
	40	4	9	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER, Nepoleon B. Conrad.

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Martha Hamrick

13-BIRTHPLACE OF MOTHER (State or Country), W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. P. Vandevender

(Address) Linwood W. Va.

15- Filed AUG 18 1921, 191.....

[illegible] I [illegible]

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 9 1911, to August 18 1921, that I saw her alive on August 17 1911, and that death occurred, on the date stated above, at 2 45 A m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

C

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

..... (Duration) ? yrs. ..... mos. ..... ds.

(Signed) Frank DeWoody Worthington M. D.

Aug 18, 1921. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 10 ds. In the State ..... yrs. ..... mos. 11 ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence West Virginia

19-PLACE OF BURIAL OR REMOVAL, Valley Head W Va — DATE OF BURIAL, Aug 19, 1921.

20-UNDERTAKER John Herwig & Co — ADDRESS 2008 Alameda St.

Motto

D 56253

HEALTH DEPARTMENT—CITY OF BALTIMORE

Belair Rd

CERTIFICATE OF DEATH.

D 56253

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 824 Belair Rd & Belt Sts; St.; 17 Ward)

REGISTERED No. C 175-001

2-FULL NAME Mrs. Mary Motto

(Residence in Baltimore: No. 824 Druid Hill ave St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1891
(Month) (Day) (Year)

7-AGE, 30 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joe Bower

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Anna Scypeens.

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Ca ave

15- AUG 18 1921 Filed ....., 191.... ROBERT I. GRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 16, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Injuries received by being run over by a Motor Truck (Accident)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) John J. Morrissey M. D.
(Coroner.)

Aug 18, 1921 (Address) 3632 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Bethesda Md

DATE OF BURIAL, Aug 19, 1921

20-UNDERTAKER Daniel Easton

ADDRESS 916 Ca ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 56254

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-089 D 56254

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 N Arlington Ave ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E Thomis

(a) RESIDENCE NO. 921 N Arlington Ave ST., WARD 16

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Public School

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Thomis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Christine Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Mary E Thomis (Address) 921 N Arlington Ave

15 Filed AUG 18 1921, 19 Robert P Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1921, to Aug 17, 1921, that I last saw h alive on Aug 16, 1921, and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) F M Lumpkin, M. D.

(Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Aug 19 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1701 W Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56255

CERTIFICATE OF DEATH.

172 D 56255

REGISTERED NO.

1-PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST.: 15 WARD)

2-FULL NAME Napoleon B. Harding

(a) RESIDENCE. NO. 3908 Dalrymple Ave. ST. ~~Forest~~ WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Treasa d Harding

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 90 yr. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman 1

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: L. M. Sherwood
(Address): 3906 Dalrymple Ave

15 Filed: Robert P. Harrison. Registrar

AUG 18 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1921, to Aug 17, 1921, that I last saw him alive on Aug 17, 1921, and that death occurred, on the date stated above, at 6.15 a m.

The CAUSE OF DEATH* was as follows:

Senility—
General Arterio Sclerosis.

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary): Fracture of L of humerus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3906 Dalrymple Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W B Jones, M. D.

Aug 19 1921 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Aug 19 1921

20 UNDERTAKER: Chenowith & Son — ADDRESS: Chestnut St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56256 ✓ D 56256

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3650 Maple Ave ST., 13 WARD)

2-FULL NAME Grace M. Hubbs.

(a) RESIDENCE NO. 3650 Maple Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23/1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	0	2	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER David H. Hubbs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Bagley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant David H. Hubbs (Address) 3650 Maple Ave.

15 Robert P. Harrison, 19..... Registrar
Burial Permit Clerk

AUG 18 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1921

17

I HEREBY CERTIFY, That I attended deceased from aug 14, 1921, to aug 17, 1921,

that I last saw her alive on aug 17, 1921

and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows: Convulsions (Spasms)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Entero-Colitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at Place of death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) S. A. Wantz M. D.

Aug 18 1921 (Address) 865 N. 36 city

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Franklin

DATE OF BURIAL 8 19 1921

20 UNDERTAKER Tennow Watson

ADDRESS 361 Chestnut ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B 56237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2317 E. Monument ST.; 7 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Marguerite Moyer

(a) RESIDENCE. No. 2317 E Monument ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? Life yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (Write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16 1910

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
11	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): ....
(c) Name of employer: ....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Clyde L Moyer
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md
12 MAIDEN NAME OF MOTHER: Florence S DeHaven
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt Md

14 Informant: Florence S DeHaven
(Address) 2317 E Monument St

15 Filed ..... 19 ..... Registrar
AUG 18 1921 Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1921

17 I HEREBY CERTIFY, That I attended deceased from November, 1920, to Aug 15, 1921, that I last saw h[illegible] alive on Aug 15, 1921, and that death occurred, on the date stated above, at 8 [illegible] m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Chronic)

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Frank Lloyd, M. D.

Aug 16, 1921 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemt	Aug 19 1921

20 UNDERTAKER: Wm Cook ADDRESS 5026 North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 56258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital ST. 25 WARD)

REGISTERED No. C 15-001 D 56258

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida. Mankoski

(Residence in Baltimore: No. Washington Rd Balto County St. (yrs., 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	married

6-DATE OF BIRTH, ... (Month) ..... (Day), 1 ..... (Year)

7-AGE,	If LESS than 1 day,
31 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home 31

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, John Blachowicz

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Zombek

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Mankowski

(Address) Washington Road

15- RECEIVED AUG 19 1921 HEALTH

Filed AUG 19 1921 Burial permit issued

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug (Month) ..... 17, (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture 5 Ribs Clavicle
Shock Internal
Injuries Auto accident

(Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(Duration) ..... yrs. ..... mos. ½ ..... ds.

(Signed) James M Fenton M. D. (Coroner.)

Aug 18, 1921. (Address) 700 E Lan[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? Washington Rd Balto Co

Former or usual residence ' ' '

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Aug 19, 1921
20-UNDERTAKER	ADDRESS
William Fallcoosk	1618 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—WRITE WITH PEN AND INDELIBLE INK

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56259

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56259

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Lemington ave St.: W. Lafayette WARD) 15

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Unnamed Infant Vogelsang.

(a) RESIDENCE. No. 12 Lemington ave St.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Newborn mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Fred Vogelsang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Pa.

12 MAIDEN NAME OF MOTHER Edna S Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Fred Vogelsang

(Address) 12 Lemington ave

15 Filed AUG 19 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1921

17 I HEREBY CERTIFY, That I attended deceased from birth Aug 18, 1921, to Aug 18, 1921, that I last saw him alive on Aug 18, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Congenital weakness

(duration) yrs. mos. Hrs ds.

CONTRIBUTORY (Secondary) Prolonged labor forceps office

(duration) yrs. mos. 9 hrs ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. I. Endor, M. D.

Aug. 19 1921 (Address) 5016 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 19 1921
20 UNDERTAKER	ADDRESS
Robt J Turner Inc	1442 N Broadway

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56260

CERTIFICATE OF DEATH.

79 D 56260

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 103 N Carey ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William V. Matthews

(a) RESIDENCE. No. 103 N Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly L. Matthews

6 DATE OF BIRTH (month, day, and year) Sep 19 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Frank E Matthews Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Frank S. Matthews

(Address) 103 N Carey St

15 AUG 19 1921 [illegible]

Burial P. [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1921, to Aug 18, 1921, that I last saw h[illegible] alive on Aug 18 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis: From history I was called in emergency Coroner Fenton oblied my signing death certificate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Evans, M. D.

, 19 (Address) 101 N. Carey.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rehoboth [illegible]	Aug 19 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1301 W. Fayette

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56261

CERTIFICATE OF DEATH.

4 7182

D 56261

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs L. Forland.

(Residence in Baltimore: No. W. Va' St.; yrs., mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Single

6-DATE OF BIRTH: ..... Nov. (Month) 18 (Day), 1894 (Year)

7-AGE: 26 yrs. 9 mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: R. R. Policeman
(b) General nature of industry, business, or establishment in which employed (or employer): 013

9-BIRTHPLACE, (State or Country), W. Va'

PARENTS.

10-NAME OF FATHER, Wm B. Forland,

11-BIRTHPLACE OF FATHER (State or Country), W. Va',

12-MAIDEN NAME OF MOTHER Mary M. Albright-

13-BIRTHPLACE OF MOTHER (State or Country), W. Va'

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. B. Forland

(Address) Terra Alta W. Va

15- AUG 19 1921 Filed ....., 191.... ROBERT E KRAUTER Registrar [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ Inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, or~~ Inquiry.) find that said deceased came to ~~his~~ death today on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in neck fired from a pistol in the hands of John Jones

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shot by John Jones'

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ~~W. K. Gore~~ ..... M. D. (Coroner.)

8-19, 1921 (Address) 117 W Davis St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Terra Alta W Va

DATE OF BURIAL, Aug 19, 1921

20-UNDERTAKER: John O. Mitchell

ADDRESS: 1731 W Fayette

Spec'd 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56262

CERTIFICATE OF DEATH.

1921 D 56262

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 532 E. 20th St. (Ward) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred A. Ives

(a) RESIDENCE. No. 532 E. 20th St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Mary T. Ives

6 DATE OF BIRTH (month, day, and year): May 29. 1855

7 AGE: Years 66; Months 2; Days 18; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ship Joiner 34

(b) General nature of industry, business, or establishment in which employed (or employer): Shipbuilder

(c) Name of employer: Hudson Cement

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thos. J. Ives

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER: Caroline Hobbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mary T. Ives 532 E 20th St

15 Filed AUG 19 1921 . 19 ROBERT I. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/17 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/16 . 19 21 . to 8/17 . 1921 .

that I last saw h. m alive on 8/17 . 21 .

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chr Int Nephr.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Grand M. D.

. 19 (Address) 518 N. Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Havre de Grace — DATE OF BURIAL: Aug 20. 21

20 UNDERTAKER: Chas. F. Grand & Son — ADDRESS: 518 N Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 56263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56263

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH 418

CITY OF BALTIMORE (No. ~~1004~~ W Lexington St ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Hecht

(Residence in Baltimore: No. 2725 W Fairmount av St.; ds., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Sept (Month) 20 (Day), 1862 (Year)

7-AGE,	If LESS than 1 day,
58 yrs. 10 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ppr Salesman, 066
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balt md

PARENTS.

10-NAME OF FATHER, Hubert Hecht

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Julia Metzger

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs B. Hecht

(Address) 2725 W Fairmount

15-

Filed AUG 19 1924, 191.... ROBERT I. KRAUTH Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 18 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 4 Days

(Duration) yrs. 4 mos. da.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) W. H. Goodwin M. D. (Coroner.)

8-18, 1924 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Aug 22, 1924
20-UNDERTAKER	ADDRESS
Lord Sondheim	1514 Pat Royal Co

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—WRITE CAREFULLY, WITH UNFADING INK

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

105

D 56264

CERTIFICATE OF DEATH.

D 56264

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2235 Ramsay St. 20 WARD)

2-FULL NAME Mary Louise Klein

(a) RESIDENCE. No. 2235 Ramsay St. 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 5-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jno Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) De.

12 MAIDEN NAME OF MOTHER Louise Limberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Jno Klein 2235 Ramsay

15 Filed AUG 19 1921 19 [illegible] Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 17 1921 to Aug 18 1921

that I last saw her alive on Aug 17 1921

and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH was as follows:

Ac Gastro-enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed dingnosis? Physical exam

(Signed) W. A Kneel M. D.

8/18, 1921 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 20 1921
20 UNDERTAKER	ADDRESS 1087
E Schulman & Son	Monroe St

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE should be properly classified. DATE OF DEATH should be carefully supplied. AGE should be properly classified. BACK of certificate should

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56265

CERTIFICATE OF DEATH.

D 56265

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1815 Hanover ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma F. Storm

(a) RESIDENCE. NO. 1815 Hanover ST., 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm N. Storm

6 DATE OF BIRTH (month, day, and year) Nov 5 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James A. Pearl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Pearl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Joseph F. March
(Address) 3515 Fremont Ave

15 Filed AUG 19 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 11. 1921. to Aug 18. 1921.

that I last saw h alive on Aug 18. 1921.

and that death occurred, on the date stated above, at 10-35 Am.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. E. Campbell, M. D.

Aug 18. 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodstock Va	Aug 20 1921
20 UNDERTAKER	ADDRESS, 321
E Schloman's Sons	Fremont

N. B.—WRITE PLAINLY. WHITE [illegible] supplied. AGE should be carefully supplied. Any information may be properly classified. Each item should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Any information may be given on back of certificates. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56266

CERTIFICATE OF DEATH.

D 56266

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 Cove ST.: 18 WARD) REGISTERED NO. 108

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margie Jones

(a) RESIDENCE. No. 213 Cove St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Jones

6 DATE OF BIRTH (month, day, and year) Aug 10 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hensel Kent Co Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Wolley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Sewell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Herman Jones
(Address) 213 Cove St

15 Filed AUG 19 1921 16 Registrar

Burial Permit Issued

N. B.—WHERE PLACE OF DEATH, AGE, OCCUPATION, CAUSE OF DEATH, ETC., are not properly classified, the certificate will be returned for correction. All information should be carefully supplied. Abbreviations should not be used in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. PUNCTUATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 5 1917, to Aug 17 1921, that I last saw h w alive on Aug 16 1921, and that death occurred, on the date stated above, at 7.30 A M.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Pelvic Inflimation

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas L Hooper, M. D.

Aug 17 1921 (Address) 3447 E 28

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Betterton Md	aug 20 1921

20 UNDERTAKER ADDRESS

R C Gross 1405 McElderry

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Appendicitis

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56267

CERTIFICATE OF DEATH

56267

REGISTERED NO.....

1-PLACE OF DEATH Nursery & Child's Hospital - 104

CITY OF BALTIMORE: (No.) Fremont & Schroeder ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Nicholes

(a) RESIDENCE. NO. Nursery & Child's Hosp. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 19-1919-

7 AGE: Years 1 | Months 10 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child - Nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore - Md.

PARENTS

10 NAME OF FATHER Peter Nicholes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece -

12 MAIDEN NAME OF MOTHER Francis Vulgaris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece -

14 Informant G. A. Fulton - Supt.
(Address) Nursery & Child's Hosp -

15 Filed AUG 18 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 21

17 I HEREBY CERTIFY, That I attended deceased from Aug. 18 - , 1921, to Aug. 18, 1921, that I last saw her alive on Aug. 18 - , 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Acute Hio-Colitis

(duration) 2 yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted
If not at place of death? .....

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Israel Strieg Cor M. D.

, 19 (Address) 2027 E. Balt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: Aug. 19, 1921

20 UNDERTAKER: George J. Smith

ADDRESS: 508 N Gay St

N. B.—WRITE PLAINLY. Words should be spelled out. All items should be carefully supplied. AGE should be properly classified. Exact statement of information should be carefully supplied. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 134

D 56268

REGISTERED NO. D 56268

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Thomas.

(a) RESIDENCE. NO. Rosedale. Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. 1 ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced (HUSBAND of) (~~the WIFE~~ of) wife of Elmer Thomas

6 DATE OF BIRTH (month, day, and year) Feb. 16 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant. (Address) Elmer Thomas Rosedale Md.

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1921, to Aug 14, 1921, that I last saw h.. alive on Aug 14, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage (Intra abdominal)

(duration) yrs. mos. 3 ds. 1

CONTRIBUTORY (Secondary) Ruptured tubal pregnancy right ovarian tube (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Rosedale Md.

Did an operation precede death? no Date of

Was there an autopsy? yes partial

What test confirmed diagnosis? Autopsy findings

(Signed) R. B. Jenks M. D.

Aug 18 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Aug 21 1921

20 UNDERTAKER Heath Casualty Co

ADDRESS Fullerton

AUG 18 1921

N. B.—WRITE PLAINLY. Blanks must be carefully supplied. Any error or omission should be corrected, so that it may be properly classified. Information should be carefully supplied, so that it may be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

14998 D 56269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 56269

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hospital ST., W WARD)

2-FULL NAME John F Hartman

(a) RESIDENCE NO. 708 S Wolfe St ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July - 1856

7 AGE 65 Years | Months | Days | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Jacob Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Conlon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Johns Hopkins Hospital Record

(Address)

15 Filed AUG 19 1921, 19 ROBERT I KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 - , 1921 , to Aug 17 - , 1921 , that I last saw h[illegible] alive on Aug 17 - , 1921 , and that death occurred, on the date stated above, at 10:55 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma jejunii gland

CONTRIBUTORY (Secondary) Pneumonia, bronchi (duration) yrs. 6 mos ds.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug. 13th

Was there an autopsy? No Exam. & operation

What test confirmed diagnosis? —

(Signed) David Holmes, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

20 UNDERTAKER J. A. Moran

DATE OF BURIAL 8/20/1921

ADDRESS 300 E Baltimore

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be understood, may be of great importance. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

56270

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 56270

CERTIFICATE OF DEATH.

152

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 S. Dallas St.: 3 WARD)

2-FULL NAME. Color Rose

(a) RESIDENCE. NO. 1031 S. Dallas ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	—	70 Min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Rose

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Greece

12 MAIDEN NAME OF MOTHER Catherine Rubin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant George Rose
(Address) 113 S Dallas St.

15 AUG 19 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from ..... 19.. to ..... 19..

that I last saw h.. alive on ..... 19..

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. G. Hoover M. D.

8.17.1921 (Address) 827 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Aug 19 1921
20 UNDERTAKER	ADDRESS
E. Sander Sons	1710 Pratt

N. B.—Blanks must be carefully supplied. Any omission or mistake in information should be carefully supplied. Any omission or mistake in CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered on certificates. See instructions on back of certificates. TION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56271 — CERTIFICATE OF DEATH. Certificate Boy 170 — D 56271

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 1400 Morrison Court St.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eveline McPherson

(Residence in Baltimore: No. 1400 Morrison Court St.; ....yrs., ...mos. ....ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6-DATE OF BIRTH: January 6, 1854 (Month) (Day) (Year)

7-AGE: 67 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: Henry Clark

11-BIRTHPLACE OF FATHER (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Mc Pherson

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Preston Clark

(Address) 1400 Morrison Court

15- Filed AUG 19 1921 ROBERT J. KRAUTER Registrar.

N. B.—Every item of information should be given, so that it may be properly entered in CAUSE OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 17, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1921, to Aug 17 1921, that I saw h[er] alive on Aug. 16 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary)

.... (Duration) ....yrs. ....mos. ....ds.

(Signed) William D. Forst M. D.

...., 191... (Address) ....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Aug. 19, 1921

20-UNDERTAKER Margaret L. Flynn — ADDRESS 1 Fremont Ave.

Spec.--6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56272

CERTIFICATE OF DEATH. 491-06

D 56272

REGISTERED NO.

1-PLACE OF DEATH University Hospital Baltimore Md. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO.

2-FULL NAME Elwood Browne

(a) RESIDENCE. NO. Union Bridge Md. ST., WARD. Union Bridge Md.

(Usual place of abode) (If nonresident give city or town and state)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsa.

PARENTS

10 NAME OF FATHER Walter Browne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ida Rowes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Hospital Records (Address)

15 Filed AUG 19 1921 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1924, to Aug 18, 1921, that I last saw him alive on Aug 18, 1921, and that death occurred, on the date stated above at .... m.

The CAUSE OF DEATH* was as follows: Streptococcic meningitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchi Pneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gram's stain

(Signed) Geo. D. Horne M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Red Fields Frederick Co. Md.

DATE OF BURIAL: Aug 21 192

20 UNDERTAKER: Harry H. Witzke

ADDRESS: 1531 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated in every case. Exact statement of DATE OF BIRTH and AGE should be carefully supplied. AGE should be properly classified. Exact statement of occupation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood by the Clerk of certificates. See instructions on back of certificate. ATTENDING PHYSICIAN'S SIGNATURE AND ADDRESS IS VERY important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

13 Bawder — 1517 E. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56273

CERTIFICATE OF DEATH.

79 ✓ D 56273

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 N. Fulton Ave ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley W. Parsons

(a) RESIDENCE NO. 839 N. Fulton Ave ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Jamie Parsons

6 DATE OF BIRTH (month, day, and year) April 24 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Star Keeper 03d
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Theodore Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER Jamie Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Jamie Parsons
(Address) 839 N. Fulton

15 Filed AUG 19 1921 19.. Registrar

ROBERT I. KRAUTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/14/ 1921, to 8/18 1921.
that I last saw him alive on 8/18 1921, and that death occurred, on the date stated above, at 1055 P m.

The CAUSE OF DEATH* was as follows: Chronic Cardiac Insufficiency

CONTRIBUTORY (Secondary) Arteriosclerosis with (duration) yrs. mos 5 ds.
Mitral Regurgitation (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) L. A. Rawlings, M. D.

19 (Address) 1517 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Aug 21 1921
20 UNDERTAKER William Cook	ADDRESS 502 E North

B.—WRITE PLAINLY. Items must be carefully supplied. Any information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 56274

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56274 ✓

CERTIFICATE OF DEATH.

8-104

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.) 410 West 29th St., (or) WARD) 17

2-FULL NAME Robert LeRoy Bollinger

(a) RESIDENCE NO. 410 West 29th St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5-1920

7 AGE — Years: — Months: 8 — Days: — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Barnie E. Bollinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot Md

12 MAIDEN NAME OF MOTHER: Annie Ruby West

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cayots town Md

14 Informant: Lennie R. Bollinger (Address) 410 W. 29th St.

15 Filed AUG 19 1921, 19 ROBERT J. BRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to Aug. 18, 1921, that I last saw him alive on Aug. 18, 1921, at 7:40 P. m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pertussis -

Marasmus

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Entero - colitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) Frank H. Meachum, M. D.

, 19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cemetery

DATE OF BURIAL: Aug 19th 1921

20 UNDERTAKER: William Cook

ADDRESS: 501 E North

N. B.—WRITE PLAINLY, WITH INK. All items should be carefully supplied. AGE should be properly classified. Exact statement of information should be carefully supplied. AGE should be carefully supplied. Exact statement of information should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D-56275

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2431 EASTERN AVE ST.: 1 . WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARTIN RYBICKI,

(a) RESIDENCE. NO. 2431 EASTERN AVE. ST., I. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 10-1902.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Can Making And day laborer,

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland,

PARENTS

10 NAME OF FATHER George Rybicki,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland,

12 MAIDEN NAME OF MOTHER Mary Jankowska,

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant (Address): Mrs, Mary Rybicka, Mother, 2431 Eastern Ave

15 Filed AUG 19 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 21

17 I HEREBY CERTIFY, That I attended deceased from [illegible] 21 to Aug 17 21.
that I last saw h[illegible] alive on Aug 16 21.
and that death occurred, on the date stated above, at 6.15 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. R. Jenkins, M. D.

, 19 (Address) 2338 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus, Cem.,

DATE OF BURIAL: Aug 20 1921.

20 UNDERTAKER: M. J. Sadowski.

ADDRESS: 905 S. Ann St

N. B.—WRITE PLAINLY. All items should be carefully supplied. Age should be properly classified. Exact statement of information should be carefully supplied. Age should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56276

CERTIFICATE OF DEATH.

79 D 56276

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 E. Fayette St ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Selby

(a) RESIDENCE. NO. 1610 E. Fayette ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Alice Selby

6 DATE OF BIRTH (month, day, and year) May 9 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'W

(c) Name of employer Arundel Sand Co Ordo, Md

9 BIRTHPLACE (city or town) (State or country) Ordo, Md

PARENTS

10 NAME OF FATHER John Selby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ordo, Md

12 MAIDEN NAME OF MOTHER Adelaide White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ordo, Md

14 Informant Charles White
(Address) 72 N. Eden St

15 Filed AUG 19 1921 ROBERT I. KRAUSS Registrar
Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 - 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1921, to Aug 17, 1921, that I last saw h[illegible] alive on Aug 15 1921, and that death occurred, on the date stated above, at 9.20 a.m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency & Mitral, cardiac hypertrophy, dilatations, congestion of kidneys, etc. (duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Island Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical, chemical

(Signed) Mayfield Boyle, M. D.

18 Aug 1921 (Address) 426 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Beale Island	Aug 19 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56277

CERTIFICATE OF DEATH.

92 D 56277

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1149 Hooker st ST.) 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Foster

(Residence in Baltimore: No. 1149 Hooker st St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug (Month) 21 (Day), 1881 (Year)

7-AGE, 64 yrs. 11 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tool Sharpener
(b) General nature of industry, business, or establishment in which employed (or employer): Tools

9-BIRTHPLACE, (State or Country) Baltimore Co Md

PARENTS.

10-NAME OF FATHER, Wm P Foster

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co Md

12-MAIDEN NAME OF MOTHER Mary Freeland

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Foster

(Address) 611 Baker's Ave

15- Filed AUG 19 1921, 191.... ROBERT J KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 16 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1921, to Aug 16 1921, that I saw h[illegible] alive on August 16 1921, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) ....yrs. ....mos. ....ds.

(Signed) C R Davis M. D.

Aug 17, 1921 (Address) 2108 Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, ~~OR REMOVAL~~ Loudon Park — DATE OF BURIAL, Aug 20 1921

20-UNDERTAKER Geo W Little — ADDRESS 2700 Edmondson Av

N. B.—Every item of information should be carefully given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56278

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2710 W. North ave (St.) 15 (Ward)

2-FULL NAME Tidpin S. Lewis

(a) RESIDENCE. No. 2710 W. North ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

920 56278

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Alwilder C Lewis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69		—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B. & O. R. R. Co

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Henry H Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Betty Taylo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Alwilder C Lewis
(Address) 2710 W. North ave

15 Filed AUG 18 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1921, to Aug 17, 1921, that I last saw him alive on Aug 17, 1921, and that death occurred, on the date stated above, at 1030 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

8/19. 1921 (Address) 1774 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 20 1921

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson

N. B.—Information should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it may be properly classified, is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Rks.

D 56279

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56279

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1425 Battery ave ST.. 24 WARD)

2-FULL NAME Sarah Elizabeth Messick

(a) RESIDENCE. NO. 1425 Battery Ave ST.. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred All 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Sommers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Not Known

14 Informant Mrs C Wiggy

(Address) 1444 Battery ave

15 Filed AUG 19 1921 19 ROBERT J. GRAFTON Registrar

Burial Permit Oleyt

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/16/21

17 I HEREBY CERTIFY, That I attended deceased from 8/10/21 . 19 . to 8/16/21 . 19 .

that I last saw her alive on 8/16/21 . 19 .

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris . M. D.

8/17 . 1921 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bells Cemetery	Aug 19 1921

20 UNDERTAKER E J Dunning ADDRESS 1460 Battery ave

N. B.—Information should be carefully supplied. All answers must be properly classified. Each statement may be true, but it may not be the whole truth, so that it may not be properly classified. Each statement should be carefully supplied. Each statement may be properly classified. Each statement should be carefully supplied. Each statement may be properly classified. Each statement should be carefully supplied. Each statement may

D 56280

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 56280

1-PLACE OF DEATH (J. McCabe Place) 79 REGISTERED No. C .....

CITY OF BALTIMORE (No Taylor & Abbotston St.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward T. Robb

(Residence in Baltimore: No. 2722 Reece st St.: 30 yrs. ..... mos. ..... ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	Colored	Married

6-DATE OF BIRTH June (Month) ....., 1874 (Day) (Year)

7-AGE 47 yrs. 2 mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE (State or country) Virginia

PARENTS

10-NAME OF FATHER Moses Robb

11-BIRTHPLACE OF FATHER (State or country) Va.

12-MAIDEN NAME OF MOTHER Ellen Latane

13-BIRTHPLACE OF MOTHER (State or country) Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Annie Howard (Niece)

(Address) Taylor & Abbotston Sts.

15- ROBERT J. REUTER

Filed AUG 19 1921 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 3, 1921, to Aug 17 1921, that I saw h— alive on Aug 17, 1921, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Myo. Cardities

(Duration) 3 yrs. ..... mos. ..... ds

Contributory (SECONDARY) arteriosclerosis

(Duration) 8 yrs. ..... mos. ..... ds.

(Signed) J. J. Stuckbon Jr M. D.

Aug 18, 1921 (Address) 632 Forrest ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Aug. 20, 1921

20-UNDERTAKER Jas. M. Johnson — ADDRESS 1234 Ellwood St.

Lambrinidis ✓

Spec.—6-9-19—M. P. Co.—1000 Bks.

14 D 56281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 D 56281 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lambrinidis

(a) RESIDENCE. NO. 711 S Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4—21

7 AGE Years 9 Months Days 8 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jim Lambrinidis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Zinka Pertesis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant (Address): Johns Hopkins Hospital Baltimore

15 Filed AUG 19 1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 7 1921, to Aug 19 1921, that I last saw he alive on Aug 19 1921, and that death occurred, on the date stated above, at 6 00 a. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery
(Final)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Stool Cultures

What test confirmed diagnosis? W Brown

(Signed) , M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: Aug 19 1921

20 UNDERTAKER: H. Sander Sons ADDRESS: 1710 Eutaw

N. B.—Answers should be carefully supplied. Any information may be properly classified. Every question should be answered so that it may be understood in plain terms, so that it

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56282

D 56282

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2503 E Hoffman ST.: 8 WARD)

2-FULL NAME Lottie Maxwell

(a) RESIDENCE. No. 2503 E Hoffman WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Maxwell

6 DATE OF BIRTH (month, day, and year) June 2 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Lewis Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Riddle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co Md

14 Informant Joseph Maxwell (Address) 2503 E Hoffman

15 Filed . 19 Robert P. Harrison, Registrar

AUG 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1924

17 I HEREBY CERTIFY, That I attended deceased from July . 1919 . to Aug 18 . 1924 . that I last saw her alive on Aug 17 . 1924 . and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Chas A Schafer, M. D.

. 19 (Address) 53 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 22 1924
20 UNDERTAKER	ADDRESS
Wm Lutz	502 E North Ave

mation should be entered in these columns, so that it may be properly classified. Use only terms in the list of certificates.
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of c

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56283

D 56283

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1606 N. Gilmor ST., 15 WARD)

2-FULL NAME Lillian Conrad

(a) RESIDENCE NO. 1606 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of Ralph J. Conrad

6 DATE OF BIRTH (month, day, and year) Nov 18

7 AGE — Years: 50 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: William Kirwan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Virginia B Shelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Sister 1606 Gilmor St

15 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

AUG 19 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to 8/18, 1921, that I last saw h[illegible] alive on 8/18, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocardial Dilatation

Contributory Edema of Lungs

Duration: 20 yrs. mos. ds.

Secondary Ca Lung Duration: 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exp.

(Signed) Henry J. Conrad M. D.

19 (Address) 1 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: Aug 21 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 56284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56284

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1522 Thames St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Joseph Schmidt

(Residence in Baltimore: No. 1522 Thames St.; yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, Mch 19th, 1866 (Month) (Day) (Year)

7-AGE, 55 yrs. 4 mos. 30 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country): Germany.

PARENTS.

10-NAME OF FATHER: Dont Know.

11-BIRTHPLACE OF FATHER (State or Country): Germany.

12-MAIDEN NAME OF MOTHER: Dont Know.

13-BIRTHPLACE OF MOTHER (State or Country): Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabette Schmidt

(Address) 1522 Thames St.

15- Robert P. Harrison,

Filed....., 191.... Registrar.

AUG 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 18th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Typhus

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....(Duration) ....yrs. ....mos. ....ds.

(Signed) Schmidt Grant Pool M. D. (Coroner)

Aug 19 1921 (Address) 1800 E Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Aug 22nd, 1921

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

1—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. All items important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56285

D 56285

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 700 S. Broadway (St.:) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Carroll

(a) RESIDENCE. (No.) 700 S. Broadway (St.) 2 (Ward)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of the late Alexander Carroll

6 DATE OF BIRTH (month, day, and year) Aug. 17th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Richard Devitt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Mary Mueller

(Address) 213 S. Ellwood Ave.

15 Filed AUG 19 1921, 19

Robert P. Harrison,

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 . 1921 . to Aug 18 . 1921.

that I last saw her alive on Aug 18 . 19 .

and that death occurred, on the date stated above, at 1.05 P.M.

The CAUSE OF DEATH* was as follows:

Coronation of tumor (cerv.)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Heart failure & Cystitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 5

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Thos. J. Buttorff, M. D.

Aug 19 1921 (Address) 1623 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Aug 22nd 1921

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 400 S. Mayfield

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56286

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56286

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital (St.:) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Minderlein

(a) RESIDENCE. No. 713 No. Streeper St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George E. Minderlein

6 DATE OF BIRTH (month, day, and year) Oct. 17th 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Pike

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Sarah Germain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant George E. Minderlein

(Address) 713 No Streeper St.

15 Filed AUG 19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE may be properly classified. Exact information should be carefully supplied, so that it may be properly classified. Exact information

(Clancey) ✓

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 56287 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56287

CERTIFICATE OF DEATH. 176

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Mercy Hospital ST.; 16 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr John Clancey.

(a) RESIDENCE. NO. 924 North Eutaw ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Sept. 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Matthew Clancy
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Bridget Fahey
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wards Mercy Hospital
(Address)

15 [illegible] 1921 Robert P. Harrison, Registrar
. 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29 . 1921. to Aug 19 . 1921.
that I last saw him alive on Aug 19 . 1921.
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Lesion Frontal Lobe
Hypertrophy
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? Yes (Date of Aug 4 1921)
(Purpose Exploratory Operation)
Was there an autopsy?
What test confirmed diagnosis? Symptoms
(Signed) John J. Brown M. D.
. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Groves	Aug 22 1921

20 UNDERTAKER Martin Fahey & Sons ADDRESS 827 N Monroe St

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be properly classified. Exact statements may be important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56288

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56288

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Jefferson (Thomas P. Jeffress)

(a) RESIDENCE. NO. Unknown 118 N. 23rd ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	~~Married~~ Unknown

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond, Virginia

PARENTS

10 NAME OF FATHER: ~~Unknown~~ Moses Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va Unknown

12 MAIDEN NAME OF MOTHER: ~~Unknown~~ Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va Unknown

14 Informant (Address): Hospital Records. New City Hospital.

15 Filed AUG 19 1921, 19 Registrar: Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 17 19 21

17 I HEREBY CERTIFY, That I attended deceased from August 12. 1921, to August 17. 1921.

that I last saw h im alive on August 16. 1921.

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy. Blood Cul.

(Signed) Clyde McNeil, M. D.

8/17/21 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chase

DATE OF BURIAL: Aug 20 1921

20 UNDERTAKER: Wm H. Chase Son

ADDRESS: 1400 Monroe

B.—Name of informant should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be of certificates. See instructions on back of TION is very important.

GENERAL AFFIDAVIT

The Daily Record Print.

State of Maryland, City of Baltimore to wit:

BE IT REMEMBERED, That on this 20th day of August A. D., 1921, before me the subscriber, a Notary Public of the said state, in and for the City of Baltimore aforesaid, personally appeared Clyde McNeill and made oath in due form of law that

DEPARTMENT OF CHARITIES AND CORRECTIONS
SUB-DEPARTMENT
SUPERVISORS OF CITY CHARITIES

LAMAR HOLLYDAY,
SUPERINTENDENT
W. H. CURRY,
ASST. SUPERINTENDENT

CITY OF BALTIMORE
MARYLAND
MUNICIPAL DEPARTMENTS

BAY VIEW HOSPITAL
HIGHLANDTOWN P. O.

August 20, 1921.

This is to certify that to the best of my knowledge the name of Thomas Jefferson as placed on his death certificate, August 17, 1921, is incorrect and should be Thomas F. Jeffress.

Signed Clyde McNeill M.D.

J. Herbert Hunt
Notary Public

#D56288

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56289

CERTIFICATE OF DEATH.

REGISTERED NO. 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 239 So. Collington Ave ST.: 1. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rolinak,

(a) RESIDENCE. NO. 239 So. Colllington Ave ST., I. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 5 Hours yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 19/21.

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland,

PARENTS

10 NAME OF FATHER Anton Rolinak,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland,

12 MAIDEN NAME OF MOTHER Angelia Pitko,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland,

14 Informant Anton Rolinak, (Father)
(Address) 239 So Collington Ave.

15 Filed AUG 19 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19. 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug 19 1921 to Aug 19 1921
that I last saw h alive on Aug 19 1921
and that death occurred, on the date stated above, at 9.00 A- m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Umbilical Cord

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Reese M. D
Aug 19 21 (Address) Fort McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Aug 20th 1921
20 UNDERTAKER W. J. Sadowski.	ADDRESS 705 S. Ann St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified

D 56290 HEALTH DEPARTMENT—CITY OF BALTIMORE 172 D 56290

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1417 E. Hoffman St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Amanda M. Price.

(Residence in Baltimore: No. 1417 E. Hoffman St. 70 yrs. 6 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	widow

6-DATE OF BIRTH, ... (Month) Jan 19 (Day), 1851 (Year)

7-AGE, 70 yrs. 6 mos. 30 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. David Bishop.

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Ellen Hanlan

13-BIRTHPLACE OF MOTHER (State or Country). Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Rumpf

(Address) 1417 E. Hoffman

15- Robert P. Harrison,

Filed....., 191.... Registrar.

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

19 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) May 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia, Gall stone Mass

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Wm. Julian M. D.
(Coroner)

5-19-21 (Address) 4 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, May 22 1921

20-UNDERTAKER Wm. M. Gaulbrecht — ADDRESS 28 E. Read Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 56291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56291

CERTIFICATE OF DEATH.

REGISTERED NO. C 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 W. Mulberry ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johanna Schmidt

(Residence in Baltimore: No. 408 W. Mulberry St St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) 2 (Day) 1858 (Year)

7-AGE, 63 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... "

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Frederick Schmelz

(Address) 408 W. Mulberry St.

15-

Filed AUG 20 1921, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

N.B.—Every item of information should be entered in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 19th, 1921.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14th 1921 to July 19th 1921, that I saw h-- alive on July 19th 1921, and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Aug. 19..., 1921 (Address) 924 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Aug. 20., 1921..

20-UNDERTAKER W. M. Roulson

ADDRESS Saratoga

D 56292 HEALTH DEPARTMENT—CITY OF BALTIMORE

175-001

D 56292

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St. Hospital St.; 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George Douglas

(Residence in Baltimore: No. 818 Vine St.; yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, April 2, 1912
(Month) (Day) (Year)

7-AGE, 9 yrs. 4 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country). Balto. City.

PARENTS.

10-NAME OF FATHER, George H Douglas

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Florence Butler

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George H. Douglas

(Address) 818 Vine St.

15- Filed ....., 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

20 1921

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tremulic Meningitis

Accidently ran into Lamp Standing struck in head (Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Concussion of Brain ..... (Duration) ..... yrs. ..... mos. 3 ..... ds.

(Signed) James W Fenton M. D.
(Coroner.)

Aug 20, 1921 (Address) 700 Chas St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 818 Vine St.

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn DATE OF BURIAL, Aug 22, 1921

20-UNDERTAKER Daniel Crowley ADDRESS 1 N Bradford St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56293

CERTIFICATE OF DEATH.

42 D 56293

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2416 Maw St ST.: 17 WARD)

2-FULL NAME Mrs Fausa Bouldin

(a) RESIDENCE. No. 2416 Maw St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fm	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Bouldin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46 yrs	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic D

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Charlotte Co, Virginia

PARENTS

10 NAME OF FATHER William Wheeler

11 BIRTHPLACE OF FATHER (city or town) Charlotte Co (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Cousin

13 BIRTHPLACE OF MOTHER (city or town) Charlotte Co (State or country) Virginia

14 Informant James Bouldin (Husband) (Address) 2416 Maw St

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

G 201921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 1921, to Aug 17, 1921, that I last saw h[illegible] alive on Aug 16th, 1921, and that death occurred, on the date stated above, at 1:15 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia?

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Diagnosis

(Signed) Geo J Hall, M. D.

, 19 (Address) 626 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Dale	Aug 20 1921
20 UNDERTAKER David S Kenney	ADDRESS [illegible]

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56294 28 ✓ D 56294

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Green & Lombard St.; 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Houck

(a) RESIDENCE. No. 330 S. Fremont St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) April 13, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Harold Houck

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Lily Marshallitter

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Hospital records
(Address)

15 Filed AUG 20 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1921, to Aug 19, 1921, that I last saw him alive on Aug 19, 1921, and that death occurred, on the date stated above, at 3.45 A.m.

The CAUSE OF DEATH* was as follows:

Pleurisy with Effusion.
Leo Nitis.

(duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. 10 ds.

18 Where was disease contracted if not at place of death? 330 S. Fremont Ave.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. L. Wells, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friendship Cem	Aug 22 1921
20 UNDERTAKER	ADDRESS
H. Eichhorn Sons	Baltimore

IMPORTANT—Write information plainly in ink, in plain terms, so that it may be understood by others than yourself. Do not abbreviate. Write out CAUSE OF DEATH

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Phy. suspicions of pleurisy being tuberculous

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56295

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56295

CERTIFICATE OF DEATH.

REGISTERED NO. 452

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2729 Fenwick Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis C: H: Berger.

(a) RESIDENCE. No. 2729 Fenwick Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Katherine Krauze

6 DATE OF BIRTH (month, day, and year) Aug 21 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	II	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Portland Me.

PARENTS

10 NAME OF FATHER Moritz Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mrs Elvin Hare
(Address) 2729 Fenwick Ave

15 Filed Robert P. Harrison, Registrar

AUG 20 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1921, to Aug 18, 1921, that I last saw him alive on Aug 18, 1921, and that death occurred, on the date stated above, at 11:45 P.m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Carcinoma prostate

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Fritz & Kimzey, M. D.

8/20, 1921 (Address) 2700 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Aug 22 1921

20 UNDERTAKER John Herring & Co

ADDRESS 2008 Aliceno

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

15 0125

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 56296

B 56296 CERTIFICATE OF DEATH.

50

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.: 7 WARD)

2-FULL NAME Eleanor Luckenbrush.

(a) RESIDENCE. No. 240 St Helena Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oliver & Edw. Luckenbrush (Parents)

6 DATE OF BIRTH (month, day, and year) Aug 7, 1915.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mich.

PARENTS

10 NAME OF FATHER Edward Luckenbrush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada.

12 MAIDEN NAME OF MOTHER Olive Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed AUG 20 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18, 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1921, to Aug 18, 1921, that I last saw her alive on Aug 18, 1921, and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine & Blood tests

(Signed) W Davison, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A. A. Co	Aug 20 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 [illegible]

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

AUG 20 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56297

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56297

38

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Darsey

(a) RESIDENCE NO. 2310 Ellings ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co., Md.

PARENTS

10 NAME OF FATHER Samuel Darsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Co., Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Co. Md.

14 Informant Hospital Records
(Address) Robert P. Harrison.

15 [illegible] 19

Registrar

AUG 20 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1921, to Aug. 18, 1921, that I last saw him alive on Aug 18, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Gunshot Suicide.
Extravasation of Urine
with acute infection.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Haemorrhage & Shock.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes, Date of Aug. 18, 21.

Was there an autopsy? No.

What test confirmed diagnosis? Findings at operation

(Signed) Louis M. Tuttle, M. D.

, 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 20 1921

20 UNDERTAKER Edward Pringotd ADDRESS 1463 W. Lanv

mation should be entered, so that it may be properly classified. Page
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56298

CERTIFICATE OF DEATH.

D 56298

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 16 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias Mason

(a) RESIDENCE. NO. 907 Calhoun st. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs mos ds How long in U. S., if of foreign birth? yrs mos ds
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore 074

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Gus Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Alsopp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) K.T.H.

15 Filed AUG 20 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1921, to August 17, 1921, that I last saw him alive on August 16, 1921, and that death occurred, on the date stated above, at 6.30 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglacy M. D.

8-17-21 (Address) Municipal Tu Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 20 1921
20 UNDERTAKER	ADDRESS
Edward Finegold	1463 W. Lany

mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56299

CERTIFICATE OF DEATH.

104 D 56299

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 S. Bond ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislawa Jachinska

(Residence in Baltimore: No. 830 S. Bond St.: 1 yrs., 3 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. March 7, 1920. (Month) (Day) (Year)

7-AGE. 1 yrs. 3 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Benedikt Jachinski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Ane Tokarz

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benedikt Jachinski

(Address) 830 S. Bond St.

15-

Filed..... Robert P. Harrison, Registrar.

AUG 20 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 19, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 16 1921, to August 19 1921, that I saw h[er] alive on August 19 1921, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Marasmus

..... (Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Indigestion

..... (Duration) ....yrs. 1 mos. 14 ds.

(Signed) H. S. Svenvaldsen M. D.

8. 19., 1921 (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary

DATE OF BURIAL. Aug 20 1921

UNDERTAKER Wm Faelsovik

ADDRESS

R.—Every item of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Gastro intestinal indigestion

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonic; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—6-9-19—P. Co.—1000 Bks.

150167

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56300

CERTIFICATE OF DEATH.

150 ✓ D 56300

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wallace Strehlau

(a) RESIDENCE. NO. 1803 N. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 30 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William T. Strehlau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marion Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Johns Hopkins Hospital

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

G 201921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1921, to Aug. 19, 1921, that I last saw him alive on Aug 19, 1921, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus —

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock of operation —

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home —

Did an operation precede death? Yes Date of 8/19/21

Was there an autopsy? No —

What test confirmed diagnosis? Operation

(Signed) Jay F. Mothersill M. D.

Aug. 19, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Christ Church Forest Hill MD

DATE OF BURIAL: Aug 21 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E Ward

mation should be carefully written in ink, in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56301

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56301

CERTIFICATE OF DEATH.

108

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Maryland General Hospital ST.... WARD)

2-FULL NAME Selma Lubalet.

(a) RESIDENCE. NO. 413 North Rose ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 28. 1898.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	8	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Actress 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Waldt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Mary Veiola

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) John Sherman 11 North High St

15 Filed Robert F. Harrison, Registrar

(Burial Permit Clerk.)

G 20 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 10. 1921. to Aug 20. 1921.

that I last saw her alive on Aug 20. 1921.

and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Sub acute Appendicitis

Left Hydrosalpinx.

Hypertrophic Endometritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction. (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 12. 21.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John W Metcalf, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Aug 23 1921

20 UNDERTAKER William Cook

ADDRESS 502 North Ave

E.—Items should be carefully supplied. AGE should be correctly stated. Exact statement of AGE is important, so that it may be properly classified. Exact information should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of AGE should be carefully supplied.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56302 ✓ D 56302

8-091

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (WARD) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Virginia Delker

(a) RESIDENCE. NO. 410 N. Paca ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. (ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER John Delker

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Mary Chrest

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Mr. Charles T. Chrest

(Address) 1000 E. 40th St.

15 Filed AUG 20 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 19 1921

17 I HEREBY CERTIFY, That I attended deceased from aug 15, 1921. to aug 19, 1921. that I last saw her alive on aug 19, 1921. and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Billy Jackson, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden Md	1921

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Fall Rd

REMEMBER: Write DEATH in plain terms, so that it may be properly CLASSIFIED. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56303

CERTIFICATE OF DEATH.

REGISTERED NO. C 45

D 56303

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bridley & Lemmon St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie M. Hammond

(Residence in Baltimore: No. 1332 W Lafayette Ave St.; 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, Aug (Month) 28 (Day), 1871 (Year)

7-AGE, 53 yrs. 7 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Forrille Md

PARENTS.

10-NAME OF FATHER, George L. Fox

11-BIRTHPLACE OF FATHER (State or Country), Forrille Md

12-MAIDEN NAME OF MOTHER Marthia A Buhrman

13-BIRTHPLACE OF MOTHER (State or Country), Forrille Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto st

15- Filed AUG 21 1921, 191.... ROBERT I. ERAUTIGH Registrar.

AUG 21 1921

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 19th (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10 1921, to Aug 19th 1921, that I saw h.e alive on Aug 19th 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of kidney

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. R. Lucas M. D.

Aug 20, 1921. (Address) 614 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 9 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 1332 W. Lafayette Ave

19-PLACE OF BURIAL OR REMOVAL, Louden Park — DATE OF BURIAL, 8-23, 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

N.B.—Fill out CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56304 64 D 56304

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Solomon

(a) RESIDENCE. No. 1820 McHenry St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Maurice M Solomon (age), 1484 Newton St N.W. Washington, D.C.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed AUG 21 1921 ROBERT I. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 9 1921, to Aug 20 1921, that I last saw her alive on Aug 20 1921, and that death occurred, on the date stated above, at 2.55 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.
Cerebral Apoplexy.

(duration) 10 yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) Henry M. Thomas Jr, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	8/21 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Baltimore

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56305

CERTIFICATE OF DEATH.

50 D 56305

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 S. Potomac ST., 1 WARD)

2-FULL NAME Elizabeth Burns

(a) RESIDENCE NO. 816 S. Potomac ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William M Burns

6 DATE OF BIRTH (month, day, and year) April 16 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William M Burns

11 BIRTHPLACE OF FATHER (city or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Dover

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Catherine Burns

(Address) 710 S Potomac

15 Filed AUG 21 1921 ROBERT I. KRAUTZ Registrar

Inquest 24 [illegible] Balto St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 19 1, to Aug 19, 1921.

that I last saw her alive on Aug 18, 1921

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

1

Diabetes,

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H Conley M. D.

8-21-1921 (Address) 2258 E Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland	Aug 22 1921
20 UNDERTAKER William Cook	ADDRESS 502 E Wash

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

S.,e.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56306 ✓

64

CERTIFICATE OF DEATH.

D 56306

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 N Carlton ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caleb A. Smith

(a) RESIDENCE. NO. 109 N Carlton ST.. ..... WARD. .....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 8, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Yard

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. L. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore Maryland

12 MAIDEN NAME OF MOTHER Julia Boone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Maryland

11 Informant Barrie Coleman

(Address) 109 N Carlton Street

15 Filed AUG 21 1921 19 Burial permit issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18/1921

17 I HEREBY CERTIFY, That I attended deceased from August 16 1921 to August 18 1921 that I last saw h[illegible] alive on August 18 1921 and that death occurred, on the date stated above, at 9.20 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Howell M. D.

8/20/1921 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn

DATE OF BURIAL Aug 21 1921

ADDRESS 114 al

20 UNDERTAKER Brown & Freeland Undertakers

Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 56307

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 56307

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST., 00 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter E Gray

(a) RESIDENCE No. US Public Health Hosp. #56 Fort McHenry WARD Baltimore Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34 yrs.	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): -------
(c) Name of employer: ---

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Edgar T Rosenbrock Registrar US PHS Hosp. #56 FtMcHenry Md.

15 Filed AUG 21 1921 19 Burial Permit Given Removal

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 28 1921 to August 18, 1921.
that I last saw him alive on August 18, 1921,
and that death occurred, on the date stated above, at 12'30 P.M.
The CAUSE OF DEATH* was as follows:
Endocarditis chronic

June 28 1921 (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Sarcoma parotid gland, Rt.
---- (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? NO Date of ---
Was there an autopsy? No
What test confirmed diagnosis? Clinic Report

(Signed) Thomas R. Payne M. D.
8/18 1921 (Address) Senior Surgeon (R) US PHS Hosp. #56 Ft McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 21 1921
20 UNDERTAKER Beaver & Tilelon	ADDRESS 114 W

Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. ATTENTION is very important. See instructions on back of certificates.

D 56308

MADISON

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56308

CERTIFICATE OF DEATH.

REGISTERED NO. C

1 PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. Mercy Hospital ST. 10 WARD)

2 FULL NAME William Sharkey

(Residence in Baltimore: No. 1317 E Madison St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Wid

6-DATE OF BIRTH, ... (Month) ..... (Day), 1849 (Year)

7-AGE, 72 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Porter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Not Known

PARENTS.

10-NAME OF FATHER Not Known

11-BIRTHPLACE OF FATHER (State or Country) Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Frederick

(Address) 1317 E. Madison

15- Filed AUG 23 1921 ..... 191.....

KELLY & KRAUTER Serial Form ..... Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug. (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Inquest unable to find Cause 22-4
Fract. Pelvis + Internal Injuries
Struck by auto truck (Cause)
Fractures (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J Riley (Coroner) ..... M. D.

Aug 24 1921 (Address) 1629 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Philidelphia U. S.	Aug. 22, 1921.
20-UNDERTAKER,	ADDRESS
Jos. F. Iberr	154 D. Luzerne Ave.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. Also CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56309 ✓ 001 X 100 — D 56309

CERTIFICATE OF ~~DEATH~~ Hospital

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: No. Lombard & Greene ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William John Lupton

(a) RESIDENCE. No. Orangegrove Haven ST.: County WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March 25th 1916

7 AGE 5 Years 5 Months 16 Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Alexander Lupton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John Alexander Lupton

(Address) Orangegrove Haven County

15 AUG 6 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1921

17 I HEREBY CERTIFY, That I attended deceased from August 18, 1921, to August 21, 1921, that I last saw him alive on August 21, 1921, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Streptococcic sore throat

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Quantion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) R. Taylor, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Aug 23 1921

20 UNDERTAKER Mullen Co

ADDRESS 502 E North Ave

mation should be given in plain terms, so that it may be properly CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56310

CERTIFICATE OF DEATH.

6 104 D 56310

1-PLACE OF DEATH

CITY OF BALTIMORE: No 400 N. Curley ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Trcka

(a) RESIDENCE. NO. 400 N. Curley ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 22, 1920

7 AGE — Years: — Months: 9 Days: 27 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ———

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Trcka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Veronica Velazonsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: James Trcka
(Address): 400 N. Curley st

15 Filed: AUG 21 1921 CLERK [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1921, to Aug 18, 1921, that I last saw h[illegible] alive on Aug 19 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Gasto-Enteritis

(duration) yrs. mon. 15 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) 1709 N Bdway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Aug 22 1921

20 UNDERTAKER: Zirkler & Zirkler

ADDRESS: 1739 Eager

mation should be carefully answered, so that it may be properly classified. Use only such terms as are in common use. Do not use abbreviations or symbols. Write the CAUSE OF DEATH in plain terms

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56311

CERTIFICATE OF DEATH.

79 D 56311

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 943 Sterling ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo F. Willard

(a) RESIDENCE NO. 943 Sterling ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Lydia Willard

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Government Work

(c) Name of employer Colgate Mfg

9 BIRTHPLACE (city or town) (State or country) Gettysburg Penn

PARENTS

10 NAME OF FATHER Geo. F. Willard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Lydia Willard (Address) 943 Sterling St

15 Filed AUG 21 1921 Robert J. Lauter Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1918, to Aug 19, 1921, that I last saw h alive on Aug 19, 1921, and that death occurred, on the date stated above, at 9 P.M. The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. H. Hornstein, M. D.

8/20, 19 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	

20 UNDERTAKER	ADDRESS
Edward Gutheim	649 E Eag

mation should be carefully supplied. Exact information CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56312

6-09 D 56312

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 741 E Fort Ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Petersen. Jr.

(a) RESIDENCE. NO. 741 E. Fort Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 12 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John H Petersen

11 BIRTHPLACE OF FATHER (city or town) Curtis Bay
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ann Allen

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant John H Petersen
(Address) 741 E Fort ave

15 Filed AUG 21 1921 ROBERT P KRAUTER Registrar
Burial Permit Dista

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-19, 1921, to 8-20, 1921, that I last saw h alive on 8-20, 1921, and that death occurred, on the date stated above, at 1130 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Measles (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) P Lilio S. Fowler, M. D.

Aug 20, 1921 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Aug 22 1921

20 UNDERTAKER John H Denny — ADDRESS 715 Light St

Information should be carefully supplied. Note that it may be properly classified. Each statement CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56313

D 56313

CERTIFICATE OF DEATH.

64

76

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital, Bay View; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Simmons

(a) RESIDENCE. NO. None ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed AUG 21 1921 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18 1921

17 I HEREBY CERTIFY, That I attended deceased from August 12, 1921, to August 18, 1921, that I last saw her alive on August 18, 1921, and that death occurred, on the date stated above, at 10 P.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Atherosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

8/19/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 22 1921
20 UNDERTAKER	ADDRESS
J. J. Cowan & Son	901 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last illness must be stated. Indefinite terms, such as "Heart Failure," "Exhaustion," "Old Age," "Senility," "Infirmities of Age," "Natural Causes," "Pneumonia," "Tuberculosis," "Cancer," "Septicemia," "Blood Poisoning," "Abscess," "Gangrene," "Meningitis," "Hemorrhage," "Convulsions," "Paralysis," "Uremia," "Jaundice," "Dropsy," "Debility," "Marasmus," "Malignant Disease," "Malignant Growth," "Tumor," "Carcinoma," "Sarcoma," "Fever," "Accident," "Suicide," "Homicide," "Drowning," "Found Dead," "Burns," "Shock," "Hemorrhage," "Coma," "Asphyxia," "Suffocation," "Fracture," "Injuries," "Wounds," "Internal Injuries," "Concussion of Brain," "Multiple Injuries," "Run Over," "Crushed," "Scalds," "Drowned," "Electrocution," "Lightning," "Poisoning," "Poison," "Gunshot Wound," "Stab Wound," "Cut Throat," "Laceration," "Contusion," "Abrasion," "Bruises," "Alcoholism," "Drug Habit," "Delirium Tremens," "Morphinism," "Opium Habit," "Cocainism," "Chloroformism," "Etherism," "Addison's Disease," "Bright's Disease," "Diabetes," "Cirrhosis," "Embolism," "Thrombosis," "Endocarditis," "Myocarditis," "Pericarditis," "Meningitis," "Peritonitis," "Septicemia," "Blood Poisoning," "Abscess," "Gangrene

Spec.—6-9-19—H. P. Co.—1000 Bks.

Crawford

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56314

CERTIFICATE OF DEATH.

1044 D 56314

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hillsdale ST.: 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick E Crawford

(a) RESIDENCE. NO. Hillsdale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4/1919

7 AGE Years: 1 Months: 8 Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frederick E Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Md.

12 MAIDEN NAME OF MOTHER: Mary E Daniels

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hillsdale

14 Informant: Mary E Crawford (Address): Hillsdale

15 Filed AUG 22 1921, 19 ROBERT I. GRIFFITH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 17th, 1921, to Aug 20th, 1921, that I last saw him alive on Aug 20th, 1921, and that death occurred, on the date stated above, at 1.45 a.m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. L. Lippmann, M. D.

(Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Aug 23 1921

20 UNDERTAKER: William Cade & Bro — ADDRESS

If any of the above items are unknown, please state the reason why. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.-1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Yellow
91 D 56315

D 56315

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 S. Elwood ST., 1 WARD)

2-FULL NAME Ernest E. Mc Leroy

(a) RESIDENCE NO. 311 S. Elwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-18-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
			3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) ppd
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James E. Mc Leroy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Edith C. Crayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Falls Md

14 Informant James E. Mc Leroy
(Address) 311 S. Elwood

15 Filed AUG 22 1921 19 ROBERT A KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 20 1921

17 I HEREBY CERTIFY, That I attended deceased from 8 18, 19 21, to 8 20, 19 21,
that I last saw h alive on 8 20, 19 21,
and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism
Otitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Florence B Titlow M. D.

8 20 19 21 (Address) 311 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 22 1921
20 UNDERTAKER Wilkerson Cook	ADDRESS 502 E North Ave

IT IS IMPORTANT that this Certificate should be filled out in every particular, so that it may be properly classified. Write plainly in ink, and state the MEDICAL TERMS of CAUSE OF DEATH in plain terms, so that it may be properly classified. See reverse side for additional space. See instructions on back of certificates. MEDICAL CERTIFICATE OF DEATH is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56316

CERTIFICATE OF DEATH.

3632 167 D 56316

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill next No. 18.)

2-FULL NAME Franklin E. Fiser

(Residence in Baltimore: No. 711½ Cumberland St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Sept (Month) 7 (Day), 1919 (Year)

7-AGE: 1 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Balto Md

PARENTS:

10-NAME OF FATHER: George R. Fiser

11-BIRTHPLACE OF FATHER (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Annie E Marion

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mrs. E. Fiser

(Address): 711½ Cumberland

15- Filed AUG 22 1921 ROBERT J. KRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Aug (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, Autopsy or inquiry) and from

Burns from Explosion of Gasoline accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

found that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Signed) [illegible] M. D. (Coroner)

1921 (Address) 713 Robgate

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Loudon Park

DATE OF BURIAL: Aug 23 1921

20-UNDERTAKER: William Cook

ADDRESS: 502 E Mark

N. B.—Every item of information should be given. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified

Spez.—6-9-19—H. P. Co.—1000 Blks.

Martha Sanks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56317

92

D 56317

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 W York ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Sanks

(a) RESIDENCE. NO. 108 W York ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 5 1870

7 AGE	Years	Months	Days	If LESS than 1 day. ....hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Thomas Hollen

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Clara Sanks (Address) 108 W York St

15 Filed AUG 22 1921 ROBERT A KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1921

17 I HEREBY CERTIFY, That I attended deceased from 7 Aug. 19..., to Aug 19. 1921, that I last saw h... alive on Aug 18 1921, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. 11 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C A Finch M. D.

Aug 20. 1921 (Address) 712 S Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Aug 22 1921
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	108 W. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56318

CERTIFICATE OF DEATH.

D 56318

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1733 Wilkens Ave. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Jane Esender

(a) RESIDENCE. NO. 1733 Wilkens Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Esender

6 DATE OF BIRTH (month, day, and year) Feb. 20th 1842

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	5	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Absolum Stinchcomb

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Edward H. Esender (Address) 1733 Wilkens Ave.

15 Filed AUG 22 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18 . 1921 . to Aug 19 . 1921 .

that I last saw her alive on Aug 19 . 1921 .

and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia -

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) - (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Chas A. Schaefer, M. D.

8/20" 1921 (Address) 53 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery DATE OF BURIAL Aug 22" 1921

20 UNDERTAKER Joseph L. B Cook ADDRESS 1003 W. Baltimore

TION is very important. See instruction

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56319

CERTIFICATE OF DEATH.

81 D 56319

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3900 Old Frederick Road ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Kupferschmidt

(a) RESIDENCE. No. 3900 Old Frederick Road WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Kupferschmidt

6 DATE OF BIRTH (month, day, and year) Nov. 19th 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlesville, Virginia

PARENTS

10 NAME OF FATHER Mr. Clements

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Frederick Kupferschmidt

(Address) 3900 Old Frederick Road

15 Filed AUG 22 1921 19.. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 31 , 1921, to Aug. 19 , 1921.

that I last saw her alive on Aug 18 , 1921,

and that death occurred, on the date stated above, at 10.30A. m.

The CAUSE OF DEATH* was as follows:

0737

Senile Arterio Sclerosis

(duration) 6+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Skilling, M. D.

8-19, 1921 (Address) 4107 Liberty Hgts Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 22 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 N. Balto St

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No terminal hemorrhage.
No intestinal indigestion.
Due to something she
had eaten.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56320 | 104 D 56320

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2229½ W. Pratt ST.: (WARD) 20th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren F. Ripley

(a) RESIDENCE. No. 2229½ W Pratt ST., 20th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 9 mos. 13 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Fred'k L. Ripley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Bedsel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Fred. F. Ripley 2229½ W. Pratt St.

15 Filed AUG 22 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-19-1921

17 I HEREBY CERTIFY, That I attended deceased from 8/19- 1921 to 8-19- 1921.

that I last saw him alive on 8-19- 1921.

and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis (Spasms) 1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of no

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) R Hollis Hunnicutt, M. D.

(Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 24 Aug 1921

20 UNDERTAKER: F B. Wippert — ADDRESS: 2336 Fred'k Ave

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56321

CERTIFICATE OF DEATH.

54 D 56321

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 Somerset. St. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. A. Haberkorn

(a) RESIDENCE. NO. 1007 Somerset. St. ST. 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. - mos. - ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Theresa Haberkorn

6 DATE OF BIRTH (month, day, and year) June. 24. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery& provision bussiness

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Haberkorn

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Mrs Theresa Haberkorn (Address) 1007 Somerset St

15 Filed AUG 22 1921 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19. 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1. 19 21. to Aug 19. 19 21. that I last saw him alive on Aug 19. 19 21. and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Senile Disease

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) 1 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Gould M. D.

8/22 1921 (Address) 4132 Wisteria

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug 23 1921
20 UNDERTAKER Henry Storch Son	ADDRESS 1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56322

CERTIFICATE OF DEATH.

40 D 56322

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2034 Ellsworth St. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Karas

(a) RESIDENCE. No. 2034 Ellsworth st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of The late Anna Karas

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE — Years: 57 yrs. — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Grave digger

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Europe

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Mary A. Hajeck
(Address) 2034 E. Ellsworth St.

15 Filed AUG 22 1921 ROBERT I. KRAUTZ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20. 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1921, to Aug 20, 1921, that I last saw h... alive on Aug 19, 1921, and that death occurred, on the date stated above, at 7.15 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

about 1 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. B. Kahn, M. D.

June 23, 19 (Address) 8304 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug 24 1921

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1301 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D 56323 — 47 D 56323

REGISTERED NO.

1 PLACE OF DEATH Rennert Hotel

CITY OF BALTIMORE: (No. Saratoga & Cathedral ST.; 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Wright Smith

(a) RESIDENCE. NO. Rennert Hotel ~~or~~ WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 80				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home - 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER General H C. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Connecticut

12 MAIDEN NAME OF MOTHER Louisa Brodford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Dr. W. D. Lockwood (Address) 8 E. Eager St.

15 Filed AUG 22 1921, 19 ROBERT J. LEIDER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb-16, 1921, to Aug 19th, 1921, that I last saw her alive on Aug 14th, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

about 2 yrs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis?

(Signed) Wm. D. Lockwood M. D.

, 19 (Address) No 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clinton Connecticut	Aug 25 1921
20 UNDERTAKER Henry H Jenkins Son & Co	ADDRESS Cycle & Mc Culloh St

mation should be entered, so that it may be properly ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

rc. 6-9-19—H. P. Co.—1000 Bks.

D 56324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56324

X 39

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (NO Maryland General Hospital ST.; WARD)

2-FULL NAME Edward Owens.

(a) RESIDENCE. NO. Earleigh Heights Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 29 1864.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	6.	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Robert Owens.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Owens.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Charles Owens
(Address) 3108 Fait Ave

15 Filed AUG 23 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18- 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15. 1921. to Aug 18. 1921.
that I last saw him alive on Aug. 18. 1921.
and that death occurred, on the date stated above, at 12-15 Pm.
The CAUSE OF DEATH* was as follows:
Carcinoma of Tongue and Mouth.

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Earleigh Heights Md
Did an operation precede death? No Date of Aug 18. 1921
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) John D. Spalding, M. D.
, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Aug 22 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	710 Fait St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56325 D 56325

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 S. Wolfe ST., V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hobart Bristol

(a) RESIDENCE NO. 524 S. Wolfe ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William Hobart Bristol

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Susie Laughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Susie Hobart Bristol
(Address) 524 S. Wolfe St

15 Filed AUG 22 1921 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1921, to Aug. 21, 1921.

that I last saw him alive on Aug. 20 1921

and that death occurred, on the date stated above, at 2 48 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? no

(Signed) John H. Rehberger M. D.

(Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery	Aug 22 1921
20 UNDERTAKER H. Sander & Sons	ADDRESS 1710 Mad Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. Age should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

BUREAU PRINTING OFFICE

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 56326

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2720 StPaul ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Jane Barnes

(a) RESIDENCE. NO. 2720 StPaul ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Jacob-S.Barnes

6 DATE OF BIRTH (month, day, and year) August 24.1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Henry Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) America

14 Informant Maurice H.Grape

(Address) Homewood Apts.

15 Filed AUG 22 1921, 19 ~~ROTHERT & KRAUTH~~ Registrar

~~Serial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21.1921 19

17

I HEREBY CERTIFY, That I attended deceased from July 18 . 1921 . to August 21 . 1921 .

that I last saw her alive on August 21 . 1921 .

and that death occurred, on the date stated above, at 1:30 A . m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis & Myocarditis, Chronic

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY Arterio-Sclerosis-

Secondary Cerebral, (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gordon Street, M. D.

, 19 (Address) 717 Park Ave Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	8-23-21 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N. Broadway

N. B.—WRITE PLAINLY, WITH INK. ALL ITEMS MUST be stated. EXACT STATEMENT OF OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Ileene H Howard.

Spec.—6-9-19—H. P. Co.—1000 Bks.

56327

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 D 56327

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1141 Ward St. ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ileene H Howard

(a) RESIDENCE. NO. 1141 Ward ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year) Sept 6, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. city Md

PARENTS

10 NAME OF FATHER: Chas E. Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto city Md

12 MAIDEN NAME OF MOTHER: Minnie E. Rau

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. city Md

14 Informant: Chas E. Howard

(Address) 1141 Ward St

15 Filed AUG 22 1921 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/21/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/20/21, 19..., to 8/21/21, 19..., that I last saw h[illegible] alive on 8/21/21, 19..., and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Auto Intoxication

(duration) ..... yrs. ..... mos. / ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen D Davis, M. D.

19..., (Address) 1727 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	Aug 23 1921
20 UNDERTAKER	ADDRESS
Chas F. Wasmus	2038 W. Pratt

CAUSE OF DEATH in plain terms, so that a stranger can understand. Do not use abbreviations or technical terms. Do not state mode of dying, such as heart failure, asthenia, etc., but the disease or injury which caused death. Indefinite or incomplete answers cannot be accepted. QUESTIONS 18 TO 20 ARE OF GREAT MEDICO-LEGAL IMPORTANCE. Be sure that your answers are full and complete. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56328

CERTIFICATE OF DEATH.

176 D 56328

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto General Hospital ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Myers

(a) RESIDENCE. NO. 201 N. Fulton Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Emma Myers

6 DATE OF BIRTH (month, day, and year) Apr. 15, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60.	4.	5.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales man. 666

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Union Mills (State or country) Md.

PARENTS

10 NAME OF FATHER Josie Myers

11 BIRTHPLACE OF FATHER (city or town) Union Mills (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Rogers.

13 BIRTHPLACE OF MOTHER (city or town) Union Mills (State or country) Md.

14 Informant Emma Myers.

(Address) 201 N. Fulton ave.

15 Filed AUG 22 1921 ROBERT B. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1921

17 I HEREBY CERTIFY, That I attended deceased from August 16, 1921, to Aug. 20, 1921, that I last saw h.. alive on August 20, 1921, and that death occurred, on the date stated above, at 855 A. m.

The CAUSE OF DEATH* was as follows:

Acute Uraemia

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostatic Hypertrophy

..... (duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Aug. 18-21.

Was there an autopsy? Yes. (Partial).

What test confirmed diagnosis?

(Signed) James Hubert Wilkerson M. D.

. 19 (Address) South Balto Gen. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mechanicsburg Pa.	Aug 23. 1921
20 UNDERTAKER George J. Smith	ADDRESS 1000 W. Fayette St

Before a certificate of death can be filled out, a PHYSICIAN must be called to view the body and must sign the MEDICAL CERTIFICATE OF DEATH. It may be prepared by the undertaker, but the CAUSE OF DEATH in plain terms, so that it may be properly classified, must be given by the physician. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56329

CERTIFICATE OF DEATH.

64 D 56329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 Carey Ext. near North Ave. ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Barber

(a) RESIDENCE. NO. 9 Carey Ext Ended. ST., 15 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 17. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter. 52

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Barber

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Margaret Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs John. Barber (Address) 110 E Oxford St.

15 Filed AUG 22 1921 ROBERT I. CRAIG Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1921.

17 I HEREBY CERTIFY, That I attended deceased from July, 1919, to August 20, 1920, that I last saw him alive on August 20, 1921, and that death occurred, on the date stated above, at 4-30 p.m.

The CAUSE OF DEATH* was as follows:

General Lymphology.

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clarence Schulteis M.D.

(Address) 1342 W Lanvale Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 23 1921

20 UNDERTAKER	ADDRESS
Sarah Boyer	160 Caroline North

CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. TION is very important. See instructions on back

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

28 ✓

CERTIFICATE OF DEATH.

D 56330

REGISTERED NO. D 56330

1-PLACE OF DEATH E. D. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 2616 Fairmount Ave.

2-FULL NAME Frances Beck

(a) RESIDENCE. No. 2616 Fairmount Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Beck

6 DATE OF BIRTH (month, day, and year): Dec. 23rd 1871

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
49	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Adam Begs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Magdalena

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Wm. Beck 2616 Fairmount Ave.

15 Filed AUG 22 1921 19. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/1/21, 19..., to 8/20/21, 19..., that I last saw h[illegible] alive on 8/20/21 at 1:45 P m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nurse (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathology

(Signed) H. Wortzman M. D.

, 19 (Address) 29 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem.

DATE OF BURIAL: Aug 24 1921

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans St

Before signing, be sure that you have personally answered each question in this certificate, so that it may be complete and accurate. Sign certificate in ink. Write plainly and use only standard abbreviations. Do not use ditto marks. Make no erasures. Be particular to fill all blanks. Write CAUSE OF DEATH in plain terms, so that it may be properly classified. Omissions will delay burial permit. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56331 — 64 D 56331

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1303 N. Rose St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda E. Jeffs

(a) RESIDENCE. No. 1303 N. Rose St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of Wm. S. Jeffs

6 DATE OF BIRTH (month, day, and year) June 14th 1848

7 AGE — Years: 73 — Months: 2 — Days: 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Ind.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind.

14 Informant: Filderz Jeffs
(Address) 2319 E. Federal St.

15 Filed AUG 22 1921 19 ROBERT I. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to Aug 20, 1921, that I last saw h 9s alive on Aug 20, 1921, and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) F. E. Kessler M. D.

Aug 21, 1921 (Address) 1301 N Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Manchester Carroll Co. Ind.

DATE OF BURIAL: Aug 23rd 1921

20 UNDERTAKER: Philip Hennig

ADDRESS 2016 Orleans St

IMPORTANT—Answer all questions in ink, in plain terms, so that it may be understood by those who use the information contained in this CERTIFICATE OF DEATH in the compilation of statistics and in the registration of certificates. CAUSE OF DEATH is very important. See instructions on back of this certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 56332

D 56332

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Schreiber

(a) RESIDENCE. NO. 224 Asquith st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown 18 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? 18 yrs. 1 mos. 9 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10th 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at German Orphan Asy.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Schreiber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Kerner ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed AUG 22 1921 ROBERT A. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from August 3 . 19 21. to August 19 . 19 21.

that I last saw h er alive on August 19 . 19 21.

and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Badagliacca M. D.

8-20-21 (Address) Municipal T.B. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Aug 22 1921
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Orleans

mation should be given in answer to each question. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56333

CERTIFICATE OF DEATH.

28 D 56333

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Johnson

(a) RESIDENCE. No. 821 Raborg st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Stephen Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Harriett Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

11 Informant: Hospital Records
(Address) M.T.H.

15 Filed AUG 22 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1921, to August 18, 1921, that I last saw him alive on August 18, 1921, and that death occurred, on the date stated above, at 10. p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglisch, M. D.

8-1-21. (Address) Municipal Tb Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Aug 23 1921
20 UNDERTAKER: John W Henderson	ADDRESS 1502 E. Monument

CAUSE OF DEATH in plain terms, so that no other cause can be substituted at any time. See instructions on back of certificates. TION is very important.

Steria Siscione

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56334

1501 1/2 S

HEALTH DEPARTMENT—CITY OF BALTIMORE

14 D 56334

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. Johns Hopkins Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Steria Siscione

(a) RESIDENCE. NO. 214 S Eden St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7-1920

7 AGE Years: — Months: 8 Days: 14 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER Catsto Siscione

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER Wilhelmina Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed AUG 22 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20- 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 17 -. 1921. to Aug 20 -. 1921.

that I last saw her alive on Aug 20 -. 1921.

and that death occurred, on the date stated above, at 11 (A.M.) P.M.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) — yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W. Davison, M. D.

(Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincents

DATE OF BURIAL: Aug 22 1921

20 UNDERTAKER: William Fiaschowski

ADDRESS: 618 Easton

mation should be given in plain terms, so that it may be properly CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

Audrzjewski

D 56335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56335

CERTIFICATE OF DEATH.

145

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE. (No. 102 3rd Ave, East Brooklyn ST.; 35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Audrzjewski

(Residence in Baltimore: No. 102 3d Ave E Brooklyn ST.; Co. yrs., mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Infant

6-DATE OF BIRTH. Aug 11, 1931 (Month) (Day) (Year)

7-AGE. ....yrs. ....mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country). East Brooklyn

PARENTS.

10-NAME OF FATHER. Joseph Audrzjewski

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Bowers Dziwanowski

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Audrzjewski

(Address) East Brooklyn

15-

Filed AUG 22 1931 ROBERT A KRAUTER Registrar

CAUSE OF DEATH in plain terms. Be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 21, 1931 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Aug 11 1931, to Aug 21 1931, that I saw h[illegible] alive on Aug 20 1931, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Bronchial

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Aug 22, 1931 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

17-PLACE OF BURIAL OR REMOVAL. Holy Rosary

DATE OF BURIAL, Aug 25 1931

18-UNDERTAKER [illegible]

ADDRESS 168 Fallsway

Spec.--8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56336 — CERTIFICATE OF DEATH — 28 D 56336

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cor Forrest & Chase ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.))

2-FULL NAME Sister Beatrice Stewart.

(Residence in Baltimore: No. Cor. Forest & Chase St.: 18 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. ..2.. (Month) ..18.. (Day), 1882 (Year)

7-AGE. 39 yrs. 6 mos. 2 ds. — If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Washington Indiana

PARENTS.

10-NAME OF FATHER. Joseph Stewart

11-BIRTHPLACE OF FATHER (State or Country). Washington Indiana

12-MAIDEN NAME OF MOTHER Rachael Hawkins

13-BIRTHPLACE OF MOTHER (State or Country) Washington Indiana

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Mary Frances O.S.D.

(Address) St. Frances Convent E. Chase St Balto Md

15- AUG 22 1921 Filed ....., 191.... ROBERT J. BRAUN Registrar. Burial Friend Black

CAUSE OF DEATH in plain terms. All items important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. ..Aug.. (Month) ..20.. (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21 191, to Aug 20 1921.
that I saw her alive on Aug 19 1921.
and that death occurred, on the date stated above, at 10 30 P m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..yrs. 6 mos. ..ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) ..yrs. ..mos. 2 ds.

(Signed) Mary F Vaughan M. D.

Aug 21., 1921. (Address) 1225 W Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cemetery — DATE OF BURIAL. Aug. 23., 1921

20-UNDERTAKER Felix B. Ryan — ADDRESS 102 E mulberry st

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56337

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH D 56337

CITY OF BALTIMORE: (No. City Hospital, Bay View. ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellsworth Cheeseman

(a) RESIDENCE. NO. Alms House, Bay View. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant
(Address)

15 Filed AUG 22 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19 1921

17 I HEREBY CERTIFY, That I attended deceased from August 19 . 1921 . to August 19 . 1921 . that I last saw him alive on August 19 . 1921 . and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction.

10 hours. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) E. E. Broadway, M. D.

, 19 (Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Form — 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56338 ✓ 104 D 56338

REGISTERED NO.

D 56338

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Phillips

(a) RESIDENCE (Usual place of abode) Johns. Hopkins Hospital WARD.

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 3, 1921

7 AGE — Years: — Months: 6 — Days: 17 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George Humphries

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Ruth Philips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital

15 Filed AUG 22 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16 , 1921. to Aug 18 , 1921.

that I last saw h.. alive on Aug 18 , 1921.

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) — Wilson M. D.

, 19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER Commissioner Health.

AUG 2 1921

JOHNS HOPKINS HOSPITAL Records

Please print name and address of informant in full.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec. 6-9-19—H. F. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56339 ✓ D 56339

18-0154

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Gribben

(a) RESIDENCE. No. 625 W Pratt St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna F. Gribben

6 DATE OF BIRTH (month, day, and year) Feb 17 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Lunatic Asylum 30

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Edward Gribben

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Healy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Johns Hopkins Hospital Baltimore

15 Filed AUG 22 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18 1921, to Aug 20 1921, that I last saw h[illegible] alive on Aug 20 1921, and that death occurred, on the date stated above, at 10 35 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency — arteriosclerosis & insufficiency mitral valve

Heart disease for (duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Henry H. Thomas Jr M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Aug 23 1921

20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information required by law. Failure to complete and return certificate may be punished by fine. See back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56340 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56340

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1523 N. Patterson Park Ave. St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis P. Snyder

(a) RESIDENCE. No. 1523 N. Patterson Park Ave. St., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime, yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth G. Snyder

6 DATE OF BIRTH (month, day, and year) Dec. 13-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Broker's Office

(c) Name of employer Halle Stuglutz.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER G. Willian Snyder.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mollie Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto,

14 Informant Elizabeth G. Snyder

(Address) 1523 N. Patterson Park Ave.

15 Filed 8 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1921, to Aug 20, 1921, that I last saw him alive on Aug 18, 1921, and that death occurred, on the date stated above, at 7.40 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary and Laryngeal Tuberculosis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Reginald F Penn, M. D.

, 19 (Address) 1414 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/23 1921

20 UNDERTAKER Chas F. Evans & Son ADDRESS 115 W. Mt. Royal Ave

(Louis Gilmore)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56341

CERTIFICATE OF DEATH.

31 D 56341

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1324. Myrtle ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Gilmore

(Residence in Baltimore: No. 1324. Myrtle ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colord

5-SINGLE, MARRIED, WIDOWED OR DIVORCED? (Write the word.) Single

6-DATE OF BIRTH: April 27, 1912 (Month) (Day) (Year)

7-AGE: 9 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer): School

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: James Gilmore

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Annie Wilson

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) annie Gilmore

(Address) 1324 Myrtle ave

15- Robert P. Harrison,

Filed....., 191..... Registrar.

AUG 22 1921 Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 21, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

G. B. & J. Peritonitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Morrison M. D. (Coroner)

Aug 22 1921 (Address) 763 Robinson

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Aug 22 1921

20-UNDERTAKER David Easton

ADDRESS 916 Eutaw ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56342

CERTIFICATE OF DEATH.

120 D 56342

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 628 Sara Ann St.; 4 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Wilkins

(Residence in Baltimore: No. 628 Sara Ann St.; 21 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 24, 1867.
(Month) (Day) (Year)

7-AGE, 54 yrs. 4 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Night Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): Labor Odr

9-BIRTHPLACE. (State or Country) Cornwall Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Wilkins

(Address) 628 Sara Ann

15-

Filed....., 191.. Robert P. Harrison,
Registrar.

AUG 22 1921 [Burial Permit Clerk.]

CAUSE OF DEATH must be plainly written. All questions must be answered if possible. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 21, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 22 1921, to Aug 21 1921, that I saw h[illegible] alive on Aug 21 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

.....

.....

Chronic Bronchitis

..... (Duration) 0 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. O. Thompson M. D.

Aug 22 1921 (Address) 609 W. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Aug 24 1921

20-UNDERTAKER Daniel Eaton — ADDRESS 916 Pa ave

Spec.—1-10-21—M&T—1500 Bks.

(Colbert)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56343

CERTIFICATE OF DEATH.

103

D 56343

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 Dolphin ST. 17 WARD)

2-FULL NAME Richard A Colbert

(a) RESIDENCE NO. 637 Dolphin ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Colbert

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Common Labor

(b) General nature of industry, business, or establishment in which employed (or employer) 640

(c) Name of employer Foster Co. Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Colbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sophia Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Delpha Colbert

(Address) 1807 Bleecker St

15 Filed AUG 23 1921, 19..... Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/19 1921

17 I HEREBY CERTIFY, That I attended deceased from aug. 13, 1921, to aug 19, 1921, that I last saw him alive on aug 19, 1921, and that death occurred, on the date stated above, at 9:46 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Glumeral & phaunition 4

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) about yrs. 3 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm A Thompson M. D.

, 19 (Address) 619 Pine St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	aug 23 1921
20 UNDERTAKER	ADDRESS 916
Daniel Eastern	Pa ave

Information should be carefully supplied. Physicians will please state CAUSE OF DEATH in plain terms, so that it may be properly classified. NAME OF INFORMANT is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56344 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 56344

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 679 Sarah Ann ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Rose Meekins

(Residence in Baltimore: No. 679 Sarah Ann St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ..., (Month) (Day) 1864 (Year)

7-AGE, 57 yrs. ~ mos. ~ ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Don't Know

11-BIRTHPLACE OF FATHER (State or Country): Don't Know

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (State or Country): Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Meekins

(Address) 679 Sarah Ann St.

15- Robert P. Harrison,

Filed ....., 191..... Registrar.

AUG 22 1921 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 15 1921, to Aug 21 1921, that I saw her alive on Aug 20 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) 0 yrs. 1 mos. ds.

(Signed) A. B. Hughes M. D.

8/21, 1921 (Address) 765 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Taylor Island Md

DATE OF BURIAL, Aug 25, 1921

20-UNDERTAKER, Daniel Taylor

ADDRESS 916 Cathedral

CAUSE OF DEATH to be plainly written. All questions important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56345 ✓ D 56345

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 Hopewell Ct ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raleigh Gibson

(a) RESIDENCE. NO. 1430 Hopewell Ct ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) all kinds

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Fauquier Co. Virginia

PARENTS

10 NAME OF FATHER Lemuel Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maggie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Lucille Gibson
(Address) 1430 Hopewell Ct.

15 Filed . 19 Robert T. Harrison, Registrar

AUG 22 1921 Burial Permit Issued

TION is very important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 20 19 21

17

I HEREBY CERTIFY, That I attended deceased from July 1 19 21, to aug 20, 19 21,

that I last saw him alive on aug 20 19 21

and that death occurred, on the date stated above, at 12 m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Dyspepsia 3 yrs Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home of deceased

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum examination

(Signed) Charles E. Clark, M. D.

(Address) 1306 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Va	aug 23 - 21
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Same

Spec. 6-9-19—H. P. Co.—1000 Bks.

(Lackner)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56346

D 56346

50

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 Patterson Park Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Lackner

(a) RESIDENCE. NO. 746 Patterson Park Ave. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs mos ds. How long in U. S., if of foreign birth? 35 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If ~~married~~ widowed, ~~or divorced~~ (or) WIFE of Frank H. Lackner

6 DATE OF BIRTH (month, day, and year) August 27 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (own) Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Fritzenkotter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frieda Lackner (Address) 746 N. Patterson Park Ave

15 Filed AUG 22 1921 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1921, to Aug 1, 1921.

that I last saw her alive on Aug 14, 1921.

and that death occurred, on the date stated above, at 2:15 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. L. Marx M. D.

7.20 1921 (Address) 827 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Aug 23 1921

ADDRESS 2016 Orleans

20 UNDERTAKER Philip Herwig

CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. TION is very important. See instructions on back

Spcy.—6-9-19—H. P. Co.—1000 Bks.

D 56347

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56347

X 109

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST.: 4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Ellen Shipley

(a) RESIDENCE. NO. Sykesville Md. ST.. WARD. Sykesville Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 5, 1903

7 AGE — Years: 17 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Robert F Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Hatfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Robt. F. Shipley (Address) Sykesville Md.

15 Aug 22 1921 Robert F. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1921, to Aug. 22, 1921, that I last saw her alive on Aug 22, 1921, and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pregnancy (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Aug 16, 21 (Laparotomy)

Was there an autopsy? no

What test confirmed diagnosis? Findings at operation

Signs of Violence: None

(Signed) J. Arthur Corbin M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Sunnyside Md. Aug 24 1921.

Brandenburg M. E. Cemetery

20 UNDERTAKER — ADDRESS

C. M. Talbert Sykesville Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. TION is very important. See instructions on back

D 56348 HEALTH DEPARTMENT--CITY OF BALTIMORE D 56348

CERTIFICATE OF DEATH

40

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 6 E. Cross or ST.: 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2 FULL NAME William Schuerholz

(Residence in Baltimore: No. 6 E Cross. St.: 44 yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: February 25, 1845 (1845) (Month) (Day) (Year)

7 AGE: 76 yrs. 5 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 617

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Fiedrig Schuerholz

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard H Schuerholz

(Address) 2103 Lake Montebello Terrace

15. Robert P. Harrison,

Filed ..... 191 Burial Permit Clerk. REGISTRAR

G 22 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August 20, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24, 1921. to August 20 1921.
that I saw h-- alive on August 20, 1921.
and that death occurred, on the date stated above, at 6 28 m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) C H Brack[illegible] M. D.

August 20 1921 (Address) 1318 S Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Prestbury Cem

DATE OF BURIAL: Aug 23 1921

20 UNDERTAKER: E Schlaman and Son

ADDRESS 1037 Lanvale

N. B.-Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. If LESS than 1 day state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D 56349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56349

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 304 N.Mount St ST.: 19th. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Carrington.

(a) RESIDENCE. NO. 304 N. Mount St. ST. 19th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs 8 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Marred

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Carrington

6 DATE OF BIRTH (month, day, and year) Feb. 20, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Wood and Coal

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Fincastle Botetourt Co. Va.

PARENTS

10 NAME OF FATHER Lewis Carrington

11 BIRTHPLACE OF FATHER (city or town) Fincastle (State or country) Botetourt Co. Va.

12 MAIDEN NAME OF MOTHER Maria Hacket

13 BIRTHPLACE OF MOTHER (city or town) Fincastle (State or country) Botetourt Co. Va.

14 Informant Ella Carington (Wife) (Address) 304 N. Mount St

15 Filed Robert P. Harrison, Registrar

G 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19th 1920 to Aug. 20th. 1921, that I last saw him alive on Aug. 20, 1921, and that death occurred, on the date stated above, at 8:15 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (Apopalexy)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ch. Interatital Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examinati n

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 22 19 21

20 UNDERTAKER Brandt Leeland & Schmidt

ADDRESS 114

mation should be given in plain terms, so that it may be properly CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

D 56350 HEALTH DEPARTMENT--CITY OF BALTIMORE 64-091 D 56350

CERTIFICATE OF DEATH

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 309 S. Second St ST. 76 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Anna M. Coedbeck

(Residence in Baltimore: No. 309 S. Second St St.: 60 yrs. 2 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
female	white	married

6 DATE OF BIRTH May 27, 1861.
(Month) (Day) (Year)

7 AGE 60 yrs. 2 mos. 23 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Balto md

PARENTS

10 NAME OF FATHER John F Lademann

11 BIRTHPLACE OF FATHER (State or country) Balto

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Thos Jamison

(Address) 309 S. Second St

15 Robert P. Harrison,
Filed ..... 191 Burial Permit Clerk. REGISTRAR

AUG 22 1921

N. B.-Every item of information should be carefully supplied. AGE, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 20, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1921, to Aug 20 1921, that I saw h[illegible] alive on Aug 19, 1921, and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
terminal
(Duration) ... yrs. ... mos. 3 ds

Contributory Cerebral Hemorrhage
(SECONDARY)
apoplexy (Duration) ... yrs. ... mos. 7 ds.

(Signed) C A Rupschneider M. D.
5/21, 1921 (Address) 340 E East Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death?
Former or usual residence same

19 PLACE OF BURIAL OR REMOVAL Loudon Park Cem — DATE OF BURIAL 8/23/1921

20 UNDERTAKER Geo J Kuetz — ADDRESS 1735 Hanover Ave

Spec.—6-6-19—H. P. Co.—1000 Bks.

D 56351

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56351

CERTIFICATE OF DEATH.

X 104

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.)

NO. Green & Lombard ST.: 17 WARD)

2-FULL NAME Herbert Styron

(a) RESIDENCE. NO. 516 N. Eutaw ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 29th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George O. Styron

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Neva Courtney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Okla.

14 Informant (Address) Mrs. George O. Styron 1428 W. Lexington St.

15 Filed Robert P. Harrison, Registrar

AUG 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1921, to Aug 22, 1921, that I last saw him alive on Aug 22, 1921, and that death occurred, on the date stated above, at 12 i 2 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 516 N. Eutaw St.

Did an operation precede death? No Date of Aug 22 '21

Was there an autopsy? No,

What test confirmed diagnosis?

(Signed) Geo. O. Wells, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 23 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 W. Balto St

CAUSE OF DEATH in plain terms, so that it may be understood by the general public. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56352 — 104 — D 56352

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: NO. Green & Lombard ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Collins

(a) RESIDENCE. NO. 1428 N. Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2" 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Maguire B. Collins

11 BIRTHPLACE OF FATHER (city or town) Covington (State or country) Virginia

12 MAIDEN NAME OF MOTHER Irene Gooden

13 BIRTHPLACE OF MOTHER (city or town) Elkton (State or country) Virginia

14 Informant (Address) Mrs. M. B. Collins 1428 W. Lexington St.

15 Filed 19 Robert F. Harrison, Registrar

G 22 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to Aug 22, 1921, that I last saw h~~im~~ alive on Aug 22, 1921, and that death occurred, on the date stated above, at 735 a.m.

The CAUSE OF DEATH* was as follows:

~~Hydrocephalus (Internal)~~

Acute Ileo Colitis (duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Hydrocephalus. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. E. Hills, M. D.

8/22, 1921 (Address) Green & Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 23 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Pratt

CAUSE OF DEATH in plain terms, so that a person not a physician may understand it. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 56353

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 56353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., / WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Weiss or Bernard F. Wisnieuski

(a) RESIDENCE. No. 600 S. Curley st. ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? Unknown yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Weiss

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder 047

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Thomas Weiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address) M.T.H.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

G 2 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19, 19 21

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1921, to Aug. 19, 1921

that I last saw him alive on August 19, 19 21,

and that death occurred, on the date stated above, at 1.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Dadaylacc, M. D.

8-19-21 (Address) Municipal Tb Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Aug 23 1921
20 UNDERTAKER	ADDRESS
Stephen L Fralkowski	1020 S Kenwood Ave

CAUSE OF DEATH in plain terms, so that it may be intelligible to the Bureau of Vital Statistics. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56354

64 D 56354

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2046 E Hoffman (St.) (8 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vaclav Ruzicka

(a) RESIDENCE. No. 2046 E. Hoffman St., Ward

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Ruzicka

6 DATE OF BIRTH (month, day, and year) Sept 23, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookbinder

(b) General nature of industry, business, or establishment in which employed (or employer) " 064

(c) Name of employer Joseph Ruzicka

9 BIRTHPLACE (city or town) (State or country) Czechoslovakia

PARENTS

10 NAME OF FATHER Josef Ruzicka

11 BIRTHPLACE OF FATHER (city or town) Radnice (State or country) Czechoslovakia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Radnice (State or country) Czechoslovakia

14 Informant (Address) Joseph Ruzicka 2nd 30 Guilford ave

15 Filed AUG 23 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1921, to Aug 21, 1921, that I last saw h[illegible] alive on Aug 21, 1921, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 9 mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Palsy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Crook M.D.

Aug 23, 1921 (Address) 504 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Aug 23 1921
20 UNDERTAKER	ADDRESS
Frank L Crook Son	1916 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations must not be used. Indefinite terms, such as "Heart Disease," "Pneumonia," "Cancer," "Tumor," "Kidney Disease," "Paralysis," "Convulsions," "Old Age," "Infantile Debility," "Premature Birth," "Childbirth," "Accident," "Fracture," "Drowning," "Burns," "Homicide," "Suicide," "Found Dead," "Sudden Death," "Coroner's Case," "Unknown," "Not Known," "Not Stated," are not sufficient. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56355

D 56355

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH New City Hosp.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No..... ST.: 6 WARD)

2-FULL NAME Edward Roberts

(a) RESIDENCE. No. 1620 Mulligan St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ? 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particulor kind of work Tin plate Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital records
(Address)

15 Filed AUG 23 1921 ROBERT J. GRIFFITH Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1921, to Aug. 20, 1921, that I last saw him alive on Aug. 19, 1921, and that death occurred, on the date stated above, at 2 A M m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chr. diffuse Nephritis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? 1620 Mulligan St

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

8/20 1921 (Address) New City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Aug 20 21
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	716 N. Caroline.

BEFORE SIGNING BE SURE that you have answered each question. Sign and return this certificate promptly. Use black ink. Write plainly. Do not use abbreviations. Make no erasures. Be sure that it may be properly classified. Data must be complete and accurate. CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF BURIAL is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 56356

HEALTH DEPARTMENT—CITY OF BALTIMORE

115 D 56356

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 West Pratt ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Theodore M. Adams

(a) RESIDENCE NO. 416 West Pratt ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary T. Adams

6 DATE OF BIRTH (month, day, and year) Sept 1852

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Picture Frame 086

(b) General nature of industry, business, or establishment in which employed (or employer) Maker

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Adams

11 BIRTHPLACE OF FATHER (city or town) Md (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Hellen Osborne

(Address) 416 N Pratt St

15 Filed AUG 23 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 22, 1921, that I last saw him alive on Aug 22, 1921, and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Gastritis

Complications

(Enlarged liver etc)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Col. Diarrhoea

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Parrie H Catlin, M. D.

, 19 (Address) 1404 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 25 1921
20 UNDERTAKER William Cook	ADDRESS 503 E Pratt St

If this be prop... on back, of certificates.

CAUSE OF DEATH in plain terms, so that it m... TION is very important. See instructions on ba...

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56357 56357

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2044 E Federal ST.; 8 WARD)

REGISTERED NO. 64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John a Goetz.

(a) RESIDENCE. No. 2044 E Federal ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Goetz

6 DATE OF BIRTH (month, day, and year) Aug 5 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 059

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis Goetz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Minnie Goetz

(Address) 2044 E Federal St

15 Filed AUG 23 1921 ROBERT J. KRAUTER Registrar

Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1921, to Aug 21, 1921, that I last saw him alive on Aug 21, 1921, and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of dest

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual clinical

(Signed) A L Mandrea C, M. D

Aug 22, 1921 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetry	Aug 24, 1921
20 UNDERTAKER	ADDRESS
Robt L Dunn Inc	1442 N Broadway

mation should be carefully supplied. Exact statement of facts may be properly classified. Exact statement of facts may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Longnecker.

56358 HEALTH DEPARTMENT—CITY OF BALTIMORE 56358

CERTIFICATE OF DEATH.

REGISTERED NO. C 64

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 918-N. Fremont ST.: 16 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Longnecker
(Residence in Baltimore: No. 918-N. Fremont St. If not in Baltimore, give State.) (If under 1 day, hrs.; if under 1 month, ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F.
4-COLOR OR RACE: W.
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, Unknown, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 76 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Balt Md

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (State or Country) Unknown
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Annie Longnecker
(Address) Glyndon Md

15- Filed AUG 23 1921 191.... ROBERT J. KRAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (autopsy or inquiry) thereon and from the evidence obtained by said Inquest (autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
(Coroner)
Aug 22 1921 (Address) 7632 Belair Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Druid Ridge Cem
DATE OF BURIAL, Aug 24/21
20-UNDERTAKER H. F. Eckhardt
ADDRESS Reisterstown Md

N. B.—Every item must be answered in ink or typewriting, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

34 D 56359

D 56359

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 China ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Minor

(a) RESIDENCE. No. 923 China ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word)
Female	Col	Widowed

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~
(or) WIFE of John Minor

6 DATE OF BIRTH (month, day, and year) ——— 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home,

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fredericksburg Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Betsy Dobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Caroline Co Virginia

14 Informant Chester Dobson
(Address) 923 China St

15 Filed AUG 23 1921 ROBERT I. GAITHER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug, 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 10, 1919, to Aug, 20, 1921, that I last saw her alive on Aug, 20, 1921, and that death occurred, on the date stated above, at 8,30A, m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis of Bones + Glands,

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Norris Hospital.

(Signed) Wm Frandsen, M. D.

8/W. 1921 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 23 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Asisco St

mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

Spec.—8 24-14—M. & T.—2000 Bks.

D 56360

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56360

CERTIFICATE OF DEATH. Roland Park 120

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Euclid Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie Julia Spraugue

(Residence in Baltimore: No. 703 Euclid Ave. St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May (Month) 18th (Day), 1876 (Year)

7-AGE, 45 yrs. 3 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Invalid 037
(b) General nature of industry, business, or establishment in which employed (or employer): In 10 year

9-BIRTHPLACE, (State or Country), Wilmington Del

PARENTS.

10-NAME OF FATHER, John Cole

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Margaret A Boyce

13-BIRTHPLACE OF MOTHER (State or Country), Balto City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Margaret Fleischmann

(Address) 703 Euclid Ave

15- Filed AUG 23 1921, 191.... ROBERT A KRAUSE Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 22 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14 1921, to Aug 22 1921, that I saw her alive on Aug. 22 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) T. H. Dellinger M. D.

8/22/21, 191... (Address) Arlington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 25 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, Aug 24, 191..

20-UNDERTAKER H S Marshall ADDRESS 3539 Fallsway

CAUSE OF DEATH in plain terms. important. See instructions on back of certificate.

Grimes Mather

Spec. 6-9-10 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56361 14 D 56361

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hospital (ST.) 21 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grimes Mather

(a) RESIDENCE. No. 236 Rustleton Rd WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 00 - 1921

7 AGE: Years 7 Months 1 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert H. Mather

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eda Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Johns Hopkins Hospital

15 Filed AUG 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 28 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 21 - 1921, to Aug 28, 1921, that I last saw h-alive on Aug 23, 1921, and that death occurred, on the date stated above, at 6 00 a. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? yes - Stool culture -

(Signed) Horace G. Stewart, M. D.

, 19 (Address) JHH.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Garden — DATE OF BURIAL: Aug 31 19

20 UNDERTAKER: P. A. Marshall — ADDRESS: 3539 Belair Rd

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—6-4-19—H. P. Co.—1000 Bks.

D 56362

HEALTH DEPARTMENT—CITY OF BALTIMORE

50 56362

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 80I N: Maderia ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret B: Kolb.

(a) RESIDENCE. NO. 80I N: Maderia St ST.. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M: Kolb

6 DATE OF BIRTH (month, day, and year) Sept 16 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	II	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Beyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Fucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John M: Kolb
(Address) 80I N: Maderia St

15 Filed AUG 23 1921 Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug [redacted] 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug [redacted], 1920, to Aug 22, 1921, that I last saw her alive on Aug 21, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Diabetis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Wade, M. D.

, 19 (Address) 1185 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Aug25 1921

20 UNDERTAKER: John Herwig Co

ADDRESS: 2008 orleans ST

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56363

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.) 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. Stanley

(a) RESIDENCE. No. 1804 N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Door Keeper 086

(b) General nature of industry, business, or establishment in which employed (or employer) Auditorium Theatre

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William W. Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizabeth A. Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Miss Emma Stanley
(Address) 1804 N. Bond St

15 Filed AUG 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20 1921 to Aug. 21 1921

that I last saw him alive on Aug. 21 1921

and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Frank C. Marine, M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: Aug 24 1921

20 UNDERTAKER: Chas. G. Black — ADDRESS: 747 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be understood by persons in general. See instructions on back of certificates. TION is very important.

Wm E. Dixon

D 56364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56364

CERTIFICATE OF DEATH.

1924

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 23 Hospital) (WARD) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Dixon

(Residence in Baltimore: No. 1823 W Saratoga St.) 52 yrs. 10 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Sept (Month) ..... 30 (Day), ... 1868 (Year)

7-AGE, 52 yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: 086
(a) Trade, profession, or particular kind of work ..... Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Contractor

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Bradley S. Dixon

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Jane Gorman

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Dixon

(Address) 1823 W. Saratoga St.

15-

AUG 23 1924

Filed ....., 191.... Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) ..... 20 (Day), ... 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach trouble

Cancer

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm E. Dudley M. D.

(Coroner.)

8-2-3rd 1924 (Address) 11 E Eo

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Aug 24 1924

20-UNDERTAKER Chas. S. Black

ADDRESS 742 W. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 56365

CERTIFICATE OF DEATH.

138 D 56365

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 Prospect ST.: 13 WARD)

2-FULL NAME Elizabeth George

(a) RESIDENCE. NO. 111 Prospect ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Jno E. George

6 DATE OF BIRTH (month, day, and year) Mar 5/1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeping

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Allen Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary C Williams

13 BIRTHPLACE OF MOTHER (city or town) Pikesville (State or country) Maryland

14 Informant Mr. J. E. George

(Address) 111 E Prospect Ave

15 Filed AUG 23 1921 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 21 . 1924 . to Aug 21 . 1921 .

that I last saw h alive on Aug 21 . 1921 .

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal eclampsia

(Died in convulsion)

(duration) yrs. — mos. 1 ds

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Delivery Date of Aug 4/21

Was there an autopsy? No.

What test confirmed diagnosis? Personal Confirmation

(Signed) R B Norment M. D.

Aug. 24 1921 (Address) 3543 Auchentoroly Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem'y	Aug 24 1921

20 UNDERTAKER George H. Holland ADDRESS 1631 Lanvale St

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56366

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 56366

REGISTERED NO.....

1-PLACE OF DEATH 813 Edmondson

CITY OF BALTIMORE: (No. 813 - Edmondson Av ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edward Birmingham

(a) RESIDENCE: NO. 813 Edmondson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura V. Birmingham

6 DATE OF BIRTH (month, day, and year) Nov 22-1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer - 057

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Newburn N.C

PARENTS

10 NAME OF FATHER Hon Birmingham

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) a.a.Co Md (State or country)

14 Interment (Address) Mt Olivet Cem

15 Filed AUG 23 1921 19 Registrar ROBERT A KRAUTER

Burial permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1921, to Aug 20, 1921, that I last saw him alive on Aug 19, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Gustav Fordeman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leadenhall Cem	8/23/21

20 UNDERTAKER Edw J Fleming Inc 1938 Lafayette ADDRESS

Be sure that it may be made out in plain terms, so that it may be properly understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56367

CERTIFICATE OF DEATH.

78 D 56367

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 122 Callender St ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret E. O'Rourke,

(Residence in Baltimore: No. 122 Callender St St.; 14 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Dec. 16, 1906
(Month) (Day) (Year)

7-AGE, 14 yrs. 8 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, David H. O'Rourke

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Margaret Hunton.

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David H. O'Rourke

(Address) 122 Callender St

15-

AUG 23 1921 ERNEST B. KELLER

Filed....., 191..... Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1st 1920, to Aug. 22, 1921, that I saw her alive on Aug. 22, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis

.....

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) E. Hunton M. D.

8/23/ 191... (Address) 858 N. Lemmond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral	8 25, 1921
20-UNDERTAKER H. C. Brauning Sons	ADDRESS 517 N. Schroeder St

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 56368 — 120 — D 56368

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1502 Rosedale ST. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Ella Markland

(Residence in Baltimore: No. 1502 Rosedale St.: 11 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 ~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: Aug. 20, 1852 (Month) (Day) (Year)

7 AGE: 69 yrs. ... mos. 2 ds. — If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Zachary Craver

11 BIRTHPLACE OF FATHER (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Harriet Jane Gardner

13 BIRTHPLACE OF MOTHER (State or country): New York State

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Miss. Bessie Markland
(Address): 1502 Rosedale St.

15.
Filed AUG 23 1921, 191.
ROBERT J. KRAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug. 22, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 6th, 1921, to Aug. 21, 1921, that I saw her alive on Aug. 21st, 1921, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:
Senile marasmus

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY): Mild Chronic Nephritis not known

(Duration) ... yrs. ... mos. ... ds.

(Signed) S A Dodds M. D.

Aug 22, 1921 (Address) 3101 Clifton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Aug 24, 1921

20 UNDERTAKER: George J. Smith — ADDRESS: 1000 Fayette St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. If unknown, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56369

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56369

170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 Augusta Ave. ST.: 20 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Uhl

(a) RESIDENCE. No. 109 Augusta Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Uhl Jr.

6 DATE OF BIRTH (month, day, and year) Oct. 9th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Frederick Stumpf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Orth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Uhl Jr.
(Address): 109 Augusta Ave.

15 Filed AUG 23 1921 19 [illegible] Registrar
Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be understood on back of certificates. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21st 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1921, to Aug. 21, 1921, that I last saw her alive on Aug. 20 1921, and that death occurred, on the date stated above, at 10.10A. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Urinary.

(Signed) E. E. Dickey, M. D.

8/21, 1921 (Address) 142 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 24 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook.	663 N. Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56370

CERTIFICATE OF DEATH.

79 D 56370

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Peach St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Palmer

(a) RESIDENCE. No. 1017 Peach St. WARD.

(Usual place of nbode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work no

(b) General nature of industry, business, or establishment in which employed (or employer) work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Louis Palmer

11 BIRTHPLACE OF FATHER (city or town) Fredericksburg (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lillie Spence

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Louis Palmer
(Address) 1017 Peach st

15 Filed AUG 23 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1919 to Aug. 21, 1921.

that I last saw him alive on Aug. 20, 1921.

and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (Hypostatic Pneumonia), (ill 2 months)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dan Svanden, M. D.

8/22 1921 (Address) 1111 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL Aug 24 1921

20 UNDERTAKER Daniel E. Lansdale ADDRESS 1701 Bank

Burial Form 11 Olert

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56371

CERTIFICATE OF DEATH.

104 D 56371

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (ST.) 25 (WARD)

2-FULL NAME Charles Polson

(a) RESIDENCE. No. 5 Union Ave Baltimore Md WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Polson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nellie Ridgely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital

15 Filed AUG 23 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) On July 28 - 1921

17 I HEREBY CERTIFY, That I attended deceased from July 21 , 1921 , to Aug. 9 , 1921 .

that I last saw him alive on Aug 9. , 1921 .

and that death occurred, on the date stated above, at 5-45 a m.

The CAUSE OF DEATH* was as follows:

Diarrhoea not dysentery

(duration) — yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W Dawson , M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cem — DATE OF BURIAL 8/24/21

20 UNDERTAKER Easton Sons — ADDRESS Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations may be used. Fill out all items. Physician must sign certificate. Undertaker must sign certificate on back of certificates. TION is very important. See instructions on back of certificates.

D 56372

HEALTH DEPARTMENT—CITY OF BALTIMORE

169 D 56372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found floating at Booze's Shipyard REGISTERED NO. C

CITY OF BALTIMORE (No.... Foot of Montgomery St. ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Kartnasky.

(Residence in Baltimore: No. 1247 Glyndon Ave. St.; 16 yrs., ---- mos. -- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, May 1st. 1875. (Month) (Day), 1 (Year)

7-AGE, 46 yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia.

PARENTS.

10-NAME OF FATHER, John Kartnasky.

11-BIRTHPLACE OF FATHER (State or Country), Russia.

12-MAIDEN NAME OF MOTHER Anna. --------

13-BIRTHPLACE OF MOTHER (State or Country), Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Kartnasky.(wife)

(Address) 1247 Glyndon Ave.

15- AUG 23 1921, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

N.B.—Every item of information should be carefully sought for, so that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Missing Aug 19th. 1921 Body found August 22nd. 1921, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto K. Reinhardt M. D. (Coroner)

Aug. 23 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Matthai Cem.	Aug 23, 1921
20-UNDERTAKER	**ADDRESS**
John Grebliunas	423 S Pora St

D 56373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56373

CERTIFICATE OF DEATH.

REGISTERED No. C 64

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Bay View Grounds ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A Durkan

(Residence in Baltimore: No. 1403 Webster St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, W | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, — (Month) — (Day) 1858 (Year)

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Steel
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Frederick Md

PARENTS.

10-NAME OF FATHER, Jas Durkan

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas E. Durkan

(Address) 1403 Webster St.

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

AUG 23 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH August 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

8/23, 1921 (Address) 1800 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetry — DATE OF BURIAL, 8-24, 1921

20-UNDERTAKER J. J. Fahey & Sons — ADDRESS 1318 Light St

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is necessary. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56374

CERTIFICATE OF DEATH.

28 D 56374

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE NO. 1010 Warner ST. 21 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Brock.

(a) RESIDENCE NO. 1010 Warner ST., WARD. 21

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of C. F. Brock

6 DATE OF BIRTH (month, day, and year): Jan 11-1865

7 AGE: Years 56 Months 7 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: D. H. W.

(b) General nature of industry, business, or establishment in which employed (or employer): 800

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Newport Conn.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Mary Langdon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y. State

14 Informant (Address): Mrs. C. F. Brock 1010 Warner

15 Filed AUG 23 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 21 1921

17 I HEREBY CERTIFY, That I attended deceased from August 14. 1921. to August 21 1921.

That I last saw him alive on August 21 1921.

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) 1 yrs. mos. ds.

Pul. Phthisis

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G. Schwendeman M. D.

. 19 (Address) 1120 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Aug 25 1921

20 UNDERTAKER: B. Schloman & Son

ADDRESS 1387 Hanover

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. See back of certificate. TION is very important. See instructions on back

IG 231921

Spec.—1-10-21—M&T—1500 Bks.

D 56375

HEALTH DEPARTMENT—CITY OF BALTIMORE

54

D 56375

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 Hanover ST., 23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Krauch

(a) RESIDENCE NO. 1626 Hanover ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Isabella Krauch

6 DATE OF BIRTH (month, day, and year) Feby 7 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	56	6	13	

8 OCCUPATION OF DECEASED 073

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer P. B. & W. R.R. Wilmington Del

9 BIRTHPLACE (city or town) (State or country) Julius Krauch

PARENTS

10 NAME OF FATHER Julius Krauch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fanny Parry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Edw. Holtz

(Address) 1626 Hanover

15 Filed ....., 19 .....

Robert P. Harrison, Registrar

Burial Permit Clerk.

G 23 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to Aug 22, 1924, that I last saw h[illegible] alive on Aug 22, 1924, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. C. L. Campbell M. D.

Aug 23 1924 (Address) 1646 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Aug 26 1924
20 UNDERTAKER	ADDRESS
Hugh Fleming's Sons	Monument

information should be given in accordance with the following instructions. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56376

CERTIFICATE OF DEATH.

78 D 56376

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lillian & Norwood Ave. St.: 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edwin McLaughlin Sr.

(a) RESIDENCE No. Lillian & Norwood Ave. WARD. 28

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora J. McLaughlin (wife)

6 DATE OF BIRTH (month, day, and year) 1868, July 10.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 766

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary. Lucas Bros.

(c) Name of employer Lucas Bros.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Robert McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Rebecca E. McFadden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Cora J. McLaughlin (wife)

(Address) Lillian & Norwood.

15 Filed 23 1921 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18th., 1921, to July 20, 1921.

that I last saw him alive on July 14, 1921.

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

Otitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Frank M. Ogden, M. D.

19 (Address) 115 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL July 24 1921

20 UNDERTAKER W. A. Pickett & Sons

ADDRESS Nash Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information should be complete in every detail. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56377 ✓ D 56377

CERTIFICATE OF DEATH.

108

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bush & Sellman Hospital ST.; (or) WARD)

2-FULL NAME Frank R. Hurtt

(a) RESIDENCE NO. 446 N. Luzerne Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs mos da. How long in U. S., if of foreign birth? yrs mos da

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank. R. Hurtt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma J Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Hospital Records
(Address)

15 Filed AUG 23 1921 . 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 . 1921 . to Aug 23 . 1921.

that I last saw him alive on Aug 23 . 1921.

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Appendicitis .

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 22/21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. V. Pallen, M. D.

8-23 1921 (Address) 508 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cemetery	Aug 26 1921

20 UNDERTAKER Jas E Miller ADDRESS 2334 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56378

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56378

176

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Mercy Hospital ST.: 7 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John Foster

(a) RESIDENCE. No. 529 Rose ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 8 mos. ? ds. How long in U. S., if of foreign birth? — yrs — mos — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	(?)	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS
10 NAME OF FATHER Joseph Foster
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Marie ?
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs C. Miller
(Address) 2334 Liberson St

15 ..... 19 Registrar
Robert P. Harrison,
Burial Permit Clerk.

G 23 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 1921 to Aug 22 1921
that I last saw him alive on Aug 22 1921 2 P.M.
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:
Retention of urine
Extravasation of urine into scrotum, Gangrene
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes Date of Aug 20 1921
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) John J. Erdmann M. D.
19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 1921
20 UNDERTAKER Jas. C. Miller	ADDRESS 2334 Jeffers

mation should be carefully written, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably hypertrophy of prostate

Spec.—6-9-19—H. P. Co.—1000 Bks.

56379 (1) 56379 (2) 56379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 105

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mount Hope Retreat ST. 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Frederick Ford -

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. One ds. How long in U. S., if of foreign birth? 0 yrs. ~~2~~ mos. ~~One~~ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Mrs Ford -

6 DATE OF BIRTH (month, day, and year) July 14 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	63	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter - 150

(b) General nature of industry, business, or establishment in which employed (or employer) Painting

(c) Name of employer Penna R. R. Co

9 BIRTHPLACE (city or town) Phila

(State or country) Pa

PARENTS

10 NAME OF FATHER Patrick Ford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Ford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland -

14 Informant Records of Mt Hope Retreat

(Address) Mt Hope Md.

15 Filed AUG 24 1921 19 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 22nd, 1921, to Aug 23rd, 1921, that I last saw him alive on Aug 23rd, 1921, and that death occurred, on the date stated above, at 5.21 P m.

The CAUSE OF DEATH* was as follows:

Gasto-Enteritis -

abt (duration) 0 yrs. 2 mos. ~~12~~ ds.

CONTRIBUTORY (Secondary) Melancholia -

abt (duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Pa

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Aug 23rd 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	Aug 24 1921
20 UNDERTAKER STEW... & KOEN COMPANY (WIL... P. WOODS, Secretary)	ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56380

CERTIFICATE OF DEATH.

64 D 56380

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1834 26 Lombard ST., 19 WARD)

2-FULL NAME Mary E Evans

(a) RESIDENCE NO. 1834 W. Lombard ST., WARD .....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Widow of John H Evans

6 DATE OF BIRTH (month, day, and year) Oct 22/1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	72	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Edward S Manuse

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Angeline Stansbury

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant M E H Evans
(Address) 1212 Garrison Ave

15 Filed AUG 24 1921 BURIAL PERMIT ISSUED
Address 53 S Fulton Ave Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1919, to Aug 22, 1921, that I last saw her alive on Aug 22, 1921, and that death occurred, on the date stated above, at 1459 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) ..... yrs. mos. / ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptomatic

(Signed) Chas A Schaefer, M. D.

Aug 23, 1921 (Address) 53 S. Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemt | DATE OF BURIAL Aug 24 1921

20 UNDERTAKER Jos Cahn | ADDRESS 506 E North Av

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 ✓ D 56381

D 56381

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.) 1349 Druid St ST.; 21 WARD)

2-FULL NAME Benj Byrd.

(a) RESIDENCE. No. 1349 Druid ST., 21 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Blk

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harriet Byrd

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 38 — Months — Days —

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teamster

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Barbara

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Harriet Byrd 1349 Druid St

15 Filed AUG 24 1921 [illegible] Registrar

Burial Permit Oiert

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 22 21

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 21 to Aug 22 21

that I last saw him alive on Aug 22 21

and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows: OVER

Aortic Aneurism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Falconmuth M. D.

Aug 24 19 21 (Address) 1170 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Aug 25 1921

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Ba ave

IMPORTANT—Read carefully the directions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be understood by the physician in other cities. See instructions on back. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia: Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lues.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56382

CERTIFICATE OF DEATH.

1192 D 56382

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 610 Wolfpin St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Hilson

(a) RESIDENCE. NO. 610 Wolfpin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colred	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer Mrs Swartz

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Howard Glover

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Glover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Daniel Easton (Address) 916 Pa ave no sig Md

15 Filed AUG 24 1921, 19 ROBT. J. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-22-1921

17 I HEREBY CERTIFY, That I attended deceased from 8-12-1924, to 8-22-1921, that I last saw h[illegible] alive on Aug 22 1924 and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (Uremia)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) no C Carter, M. D.

, 19 (Address) 1063 Argyle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL aug 26 1921

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be classified. Physician is required to sign certificate of death and to make return of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56383

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 N. Bond ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Frazier

(a) RESIDENCE. NO. 102 N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col.	married

5a If married, widowed, or divorced
HUSBAND of (or ~~WIFE of~~) Susie Frazier

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer C&O
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Lewis Stone & Webster

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Eugene Parr
(Address) 102 N. Bond St.

15 Filed AUG 24 1921 19 [illegible] Registrar
Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from July 26 1921, to Aug. 21 1921,
that I last saw him alive on Aug. 21 1921,
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Aortic insufficiency
Dyspnea 3 yrs.
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Heart Failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know
Did an operation precede death? No Date of No.
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Mayfield Boyd, M. D.
Aug 24 1921 (Address) 405 N. Carlin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Aug 24 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 Edmondson

mation should be given in answering these questions. The
CAUSE OF DEATH in plain terms, so that it may be properly classified
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

14 19 56384 — 14 56384

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (ST.:) 16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Freier

(a) RESIDENCE. No. 918 Eutaw St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State) Virginia

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Charles Freier

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Bessie Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital Records
Address

15 Filed AUG 24 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 5 1921, to Aug 23 1921, that I last saw her alive on Aug 23 1921, and that death occurred, on the date stated above, at 10 00 P. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool Culture

(Signed) [illegible], M. D.

. 19 (Address) J H H

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run Cemetery	19 21
20 UNDERTAKER Mayo Levinton	ADDRESS 1121 E. Baltimore

MAY BE PRINTED. Information should be given in plain terms, so that it may be understood by the laity. CAUSE OF DEATH in plain terms, so that it may be understood by the laity. CAUSE OF DEATH is very important. See instructions on back of certificates.

56385

HEALTH DEPARTMENT—CITY OF BALTIMORE

56385

CERTIFICATE OF DEATH.

REGISTERED No. C 64 D 56385

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 540 Helen St.- WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. H. Smith

(Residence in Baltimore: No. 540 Helen St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 30 (Month) (Day), 1854 (Year)

7-AGE, 67 yrs. 3 mon. 24 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 0 x 3
(b) General nature of industry, business, or establishment in which employed (or employer)..... Coachman

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER. Owen Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Jacomb

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Smith

(Address) 540 Helen St

15- A

Filed..... 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest or autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) John Donnelly M. D.
(Coroner)

(Address) 1632 Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Ind Auburn Cem

DATE OF BURIAL, Aug 26 1921

20-UNDERTAKER George T. A. Gibson

ADDRESS 513 Fairmount Av

N. B. Every item of information should be given, so that it may be properly classified. Exact Residence of deceased, CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56386

D 56386

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 E Henrietta ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Fisher

(a) RESIDENCE. NO. 26 E. Hennetta ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ann Fisher

6 DATE OF BIRTH (month, day, and year) Nov 17 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer) Sail Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Glascow Scotland

PARENTS

10 NAME OF FATHER Robert Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Henry Bush
(Address) 1602 Light St

15 Filed ... 19 ... Registrar

AUG 24 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 22, 1921, that I last saw h... alive on Aug 22, 1921 and that death occurred, on the date stated above, at 4 40 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Contributory Arteriosclerosis

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Terminal Asthenia

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) ... M. D.

... 19 2 (Address) 1602 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MOUNT OLIVET. DATE OF BURIAL: AUG 25 1921

20 UNDERTAKER: JOHN F. DENNY ADDRESS: 716 LIGHT ST.

mation should be entered in plain terms, so that it may be properly coded. CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56387

104 D 56387

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No Green & Lombard ST.: 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johnnie Lutz

(a) RESIDENCE. NO 528 W. Brunswick ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 11, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Louis Lutz

11 BIRTHPLACE OF FATHER (city or town) ——
(State or country) U.S.A.

12 MAIDEN NAME OF MOTHER Mc Clocklin

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Louis Lutz
(Address) 528 Brunswick St.

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1921, to Aug 24, 1921,
that I last saw him alive on Aug 24, 1921,
and that death occurred, on the date stated above, at 1:05 AM

The CAUSE OF DEATH* was as follows:

Acute Ileo Colitis

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Exudative Diathesis

(duration) ..... yrs. ..... mos. 34 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of ——

Was there an autopsy? yes

What test confirmed diagnosis? Stool examination

(Signed) Geo. E. Dello, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Aug 25 19

20 UNDERTAKER C. W. Dill

ADDRESS 3109 Fredk Ave

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

AUG 24 1921 Registrar of Vital Statistics

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56388

CERTIFICATE OF DEATH

134 D 56388

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: No. Lombard + Greene Sts. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Ott.

(a) RESIDENCE. NO. 2722 Edmondson Ave ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Ott

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adam Noettner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant August Ott

Address 2722 Edmondson Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/22 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1921, to Aug 22, 1921, that I last saw h.. alive on Aug 22, 1921, and that death occurred, on the date stated above, at 4 PM. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage + Surgical Shock

(duration) 1 hour yrs. mos. ds.

CONTRIBUTORY (Secondary) Ectopic Pregnancy 3 months

Submucous fibroid (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 22, 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) T. B. Jones, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross R. R. Co.	Aug 24 '21
20 UNDERTAKER F. A. Krause + Son	ADDRESS 703 Hanover

4 CAUSE OF DEATH in plain terms. Abbreviations not allowed. See instructions on back of certificates.
TION is very important.

G 24192

Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56389

D 56389

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 N Appleton St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth D Lloyd

(a) RESIDENCE No. 1607 N Appleton St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 29 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	53	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer): Clerk

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm J Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Helen McKitty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Charles J Lloyd 1607 N Appleton St

15 Filed ..... Burial ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 22 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 22, 19..

that I last saw him alive on Aug 22, 19..

and that death occurred, on the date stated above, at 11 20 P. m.

The CAUSE OF DEATH* was as follows:

Tabes Dorsalis

(duration) 2 yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical changes & Wassermann

(Signed) Charles O'Donovan M. D.

Aug. 24 1921 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Aug 25 1921
20 UNDERTAKER	ADDRESS
William Cox	5026 E Madison

NOTE—WRITE PLAINLY, WITH CONTRAST. AGE should be stated mation should be carefully supplied. AGE should be properly classified. Exact statement CAUSE OF DEATH in plain terms, so that it may be used for statistical purposes. TION is very important. See instructions on back of certificates.

AUG 24 1921 Burial Permit

Dr. Chas C. Donovan 5 E Read St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Luetic infection.

Spec.—1-10-21—M&T—1500 Bks.

D 56390

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56390

CERTIFICATE OF DEATH.

24 428

REGISTERED NO.

1-PLACE OF DEATH US. PHS Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore St., Md 39 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willaim W Cephas

(a) RESIDENCE NO. US PHS Hosp. #56 ST., 39 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Willaim W Cephas

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34 yrs.	---	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Edgar T Rosenbrovk Registrar US PHS Hosp. #56 Ft McHenry Md.

15 Filed 19 Registrar

AUG 24 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1921, to Aug. 21 1921, that I last saw h. im alive on Aug. 21, 1921, and that death occurred, on the date stated above, at 9'45 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far adv. active.

June 17 /21 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) --- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Clinic record.

(Signed) Senior Surgeon (R) M. D.

8/21/21 (Address) US PHSHosp. #56 Ft McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Warrington Va

DATE OF BURIAL Aug 24, 21

20 UNDERTAKER Jno Robert A Elliott

ADDRESS 1725 Ashland Av

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56391

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56391

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 516 Mulliken St ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Gilispy

(Residence in Baltimore: No. 516 Mulliken St St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, July 12, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER. William Gilispy

11-BIRTHPLACE OF FATHER (State or Country). Kentucky

12-MAIDEN NAME OF MOTHER Fanny Pollard

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Gilispy

(Address) 1516 Mulliken St

15- ROBERT A ELLIOTT

Filed AUG 24 1921 Buried 1921 Grave Lot

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 22 1921, to Aug 23 1921, that I saw him alive on Aug 22 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows;

Gastro enteritis

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Richard L Caslington M. D.

Aug 23, 1921. (Address) 1514 E Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Aug. 24., 1921.
20-UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

AUG 24 1921

D 56392

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56392

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 622 Penn ally ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Wilson

(Residence in Baltimore: No. 622 Penn ally St., 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 41 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Wilson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Da Hour

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Sprigg

(Address) 622 Penn ally

15- ROBERT J KRAUTER

Filed ....., 191.....

NG 241921 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) D.

8-23, 1921 (Address) 1717 W Lemmon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL, Calvert Md	DATE OF BURIAL, Aug 24 1921
20-UNDERTAKER R C Gross	ADDRESS 1405 McElderry St

N.B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

Spec. – 6-9-19 – H. P. Co. – 1000 Bks.

D 56393

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56393

CERTIFICATE OF DEATH.

5 28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 5 WARD)

2-FULL NAME John E. Johnson

(a) RESIDENCE. NO. 321 Colvin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 13 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Labor

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Charlotte, N.C.

PARENTS

10 NAME OF FATHER Claude Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Minnie Clark.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina.

14 Informant (Address) J. J. Sweezy

15 Filed AUG 29 1921 H. KRAUTER Registrar

Burial Permit Issued

AUG 24 1921

mation should be complete, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20 1921

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to August 23, 1921, that I last saw him alive on August 22, 1921, and that death occurred, on the date stated above, at 9 9. m.

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination & Autopsy

(Signed) William R. Schwartz, M. D.

Aug. 23, 1921 (Address) Md. Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug. 26 1921
20 UNDERTAKER William Cook	ADDRESS 602 E Barton

Spec.—6-9-19—H. P. Co.—1000 Bks.

Emanuel Ventimiglia

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D 56394

D 56

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 N. Wheeler ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel Ventimiglia -

(a) RESIDENCE. No. 12 N Wheeler ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~
M	W	M.

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Michelina Ventimiglia.

6 DATE OF BIRTH (month, day, and year) Jan 21 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hubb Clothing Store Catonsville -

9 BIRTHPLACE (city or town) Italy -
(State or country)

PARENTS

10 NAME OF FATHER Diego Ventimiglia

11 BIRTHPLACE OF FATHER (city or town) Catonsville
(State or country) Italy

12 MAIDEN NAME OF MOTHER Pieplini + Ratellone

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Michelina Ventimiglia
(Address) 12 N Wheeler ave

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-22 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-10- 1921, to 8-22 1921.

that I last saw him alive on 8-21- 1921.

and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:

acute myocarditis -
+ valvular in -
sufficiency -

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Acute dilatation -

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) S. D'Amato, M. D.

8-22 1921 (Address) 1607 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Catherdral Cemetery	Aug. 25-1921
20 UNDERTAKER	ADDRESS
George L. Schwab & Bro.	2101 Fredk Ave.

AUG 24 1925

mation should be properly ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56395

CERTIFICATE OF DEATH.

REGISTERED NO. C 170 D 56395

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 50 N. Caroline ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Wadey

(Residence in Baltimore: No. 50 N. Caroline St. St.; life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH, May (Month) 10 (Day), 1897 (Year)

7-AGE, 44 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 870

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Wylot

(Address) 45 N. Caroline St.

15- AUG 24 1921 Filed....., 191. Robert F. Garrison, Burial Permit Clerk. Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 21 1921, to Aug 21 1921, that I saw h[illegible] alive on Aug 20 1921, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. 6 mos. ds.

(Signed) Richard H. Easbrooks M. D.

Aug 21, 1921 (Address) 45 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Chrisfield Md. DATE OF BURIAL, Aug 24, 1921

20-UNDERTAKER James H. Stinnett ADDRESS 1605 E. Monument St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56396 ✓ D 56396

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 W. Mulberry St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Roy Barton Jr.

(a) RESIDENCE. NO. 1510 W. Mulberry St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6th 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edgar R. Barton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Lottie Temple

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Edgar Roy Barton
(Address) 1510 W. Mulberry St.

15 Filed AUG 24 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23rd 19 21

17 I HEREBY CERTIFY, That I attended deceased from 6/20/, 21, to 8/23, 1921, that I last saw h— alive on 8/22/21, 19, and that death occurred, on the date stated above, at 5.35 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) thirty 2 mos. yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard Stern, M. D.

8/24, 1921 (Address) 910 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Monkton, Md.	Aug 25th 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto St

mation should be carefully answered, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-3-19/—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56397 D 56397

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. John Hopkins Hospital St.; 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Medcalf

(a) RESIDENCE. No. Runnells Court, Md St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER James Medcalf

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Martha Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) John Hopkins Hospital

15 Filed AUG 24 1921, 19 ROBERT A. BRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1921, to Aug 20, 1921, that I last saw her alive on Aug 20, 1921, and that death occurred, on the date stated above, at 10:12 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Eastern Shore Md.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Henry H. Thomas Jr. M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charleston W. Va	8 24 21

20 UNDERTAKER H. E. Tusher

ADDRESS 424 N. Broadway

mation should be furnished. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

149697.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56398

CERTIFICATE OF DEATH.

D 56398

102

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Phillips

(a) RESIDENCE. NO. 647 Josephine St. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Janie Brooks (Sister). 8C 1007 Manly Alley. Greenville

6 DATE OF BIRTH (month, day, and year): Aug 8, 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45.	—	11.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

140

9 BIRTHPLACE (city or town) (State or country): S.C.

PARENTS

10 NAME OF FATHER: Sam'l Phillips.

11 BIRTHPLACE OF FATHER (city or town) (State or country): S.C.

12 MAIDEN NAME OF MOTHER: Mary Hudley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S.C.

14 Informant (Address): Johns Hopkins Hospital

15 Filed Aug 3 1921, 19 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1921, to Aug 19, 1921, that I last saw him alive on Aug 19, 1921, and that death occurred, on the date stated above, at 10:35 P. m.

The CAUSE OF DEATH* was as follows:

Lung abscesses, both lungs
Empyema,
Bronchopneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Gastric Ulcer 1930

(duration) One yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 28 '21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL.

DATE OF BURIAL: AUG 2 1921

20 UNDERTAKER: Commissioner Health.

ADDRESS

Per. Wm. E. WOODALL

mation should be carefully compared with the CAUSE OF DEATH in plain terms, so that it may be properly classified. THON is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Tuberculous or Malignant

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56399

CERTIFICATE OF DEATH.

151 D 56399

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2634 Hanford Ave WARD)

2-FULL NAME Infant Brooks

(a) RESIDENCE NO. 2634 Hanford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
			8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Robert L. Brooks.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ella. Lylet

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Robert L. Brooks.
(Address) 2634 Hanford Ave.

15 Filed AUG 24 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/15 1921, to 8/20 1921,
that I last saw h[illegible] alive on 8/20 1921,
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Convulsions

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 8 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry T. Ewald, M. D.

1921 (Address) Roland Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden

DATE OF BURIAL 8/21 1921

20 UNDERTAKER Bennett & Son

ADDRESS 3617 Eastern Ave

Information should be carefully supplied. Each item should be properly classified. It may be properly classified, so that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 56400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56400

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9- Mary ave ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Murphy

(a) RESIDENCE. NO. 9- Mary Ave ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Murphy

6 DATE OF BIRTH (month, day, and year) 8/9/1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

837

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER C. Handreadey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John Murphy (Address) #9- Mary Ave

15 Filed AUG 24 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921, to Aug 22 1921, that I last saw h[illegible] alive on Aug 22 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Smith M. D.

Aug 24 1921 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cath. Cem.	8/25/19
20 UNDERTAKER Geo. J. Ruth.	ADDRESS 1735 Harford Ave

mation should be carefully supplied, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. State CAUSE OF DEATH in plain terms

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56401 ✓ D 56401

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Prospect Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Norris

(a) RESIDENCE. NO. 114 Prospect Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16 - 1841

7 AGE	80 Years	6 Months	7 Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 100

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City
(State or country)

PARENTS

10 NAME OF FATHER Isaac Norris

11 BIRTHPLACE OF FATHER (city or town) Stanford Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Patten

13 BIRTHPLACE OF MOTHER (city or town) Cecil Co Md
(State or country)

14 Informant Mrs Laura Dorsey
(Address) 110 Prospect Ave

15 Filed Robert P. Harrison, Registrar

AUG 24 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 14th, 1920, to Aug 23rd, 1921, that I last saw h er alive on August 23rd, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Caleb N. Athey, M. D.

Aug 23, 1921 (Address) 100 S. Patterson Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Aug 26 21

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Falls Rd

mation should be carefully supplied. Each item should be properly classified, so that it may be available for the compilation of statistics. CAUSE OF DEATH in plain terms

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56402 V091 D 56402

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 S. Bouldin ST.: 26 WARD)

2-FULL NAME Katharine E. Emmerich

(a) RESIDENCE. NO. 928 S. Bouldin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred - yrs. 11 mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Sept. 23. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	-	11	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work - pat

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Emmerick

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Clara Elliott

13 BIRTHPLACE OF MOTHER (city or town) Essex Co.,
(State or country) Va.

14 Informant Williams Emmerick
(Address) 928 S. Bouldin St.

15 Filed ....., 19 ..... Registrar

AUG 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/18/21, 19....., to 8/23/21, 19.....,
that I last saw h.er alive on 8/23/21, 19.....,
and that death occurred, on the date stated above, at 4:10 P. m.
The CAUSE OF DEATH* was as follows:

Pleurisy

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. Bruce Carroll, M. D.

, 19 (Address) 633-5-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Aug 25 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 E. Eager

mation should be given in these terms, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56403

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56403

CERTIFICATE OF DEATH.

1114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST.; N WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony F. Wright

(a) RESIDENCE. NO. 800 S 3rd ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 61yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth J. Weigert

6 DATE OF BIRTH (month, day, and year) Dec 11-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Standard Oil Co.

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Weigert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Elizabeth J. Weigert (Address) 800 S. Third St

15 Filed AUG 25 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1921

17 I HEREBY CERTIFY, That I attended deceased from August 17, 1921, to Aug 24, 1921, that I last saw him alive on Aug 24, 1921, and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Chalicky thrans

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolis 10 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 13, 21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Kourey, M. D.

. 19 (Address) 623 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Aug 27 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

mation should be entered in this column, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

149269 D 56404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

130 D 56404

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: W WARD)

2-FULL NAME Alverta Hardman

(a) RESIDENCE. No. 613 Montgomery St ST., WARD. 9

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lloyd. Hardman

6 DATE OF BIRTH (month, day, and year) Aug 9. 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore MD

PARENTS

10 NAME OF FATHER Lloyd Hardman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto MD

12 MAIDEN NAME OF MOTHER Sarah Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto MD

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed AUG 25 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1921

17

I HEREBY CERTIFY, That I attended deceased from July 6 1921 to Aug. 23 1921 that I last saw her alive on Aug 23 1921 and that death occurred, on the date stated above, at 7:02 P m.

The CAUSE OF DEATH* was as follows:

General peritonitis
Terminal broncho-
pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Pelvic Inflammatory disease (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Aug 16-21

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Kelly M. D.

Aug 25. 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Aug 26 1921
20 UNDERTAKER	ADDRESS
J. L. Evans & Son	1611 N. Monty

mation should be entered, supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Nellie C. Justice

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56405 D 56405

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 Fraser ST.; 17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Celeste Justice

(Residence in Baltimore: No. 608 Fraser St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 23rd, 1902
(Month) (Day) (Year)

7-AGE, 19 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, James Justice

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Richardson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Celeste ....

(Address) 608 Fraser St.

15- AUG 25 1921 Filed ....., 191.. Burial Permit Issued ROBERT E KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 24th 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1921, to Aug 24th 1921, that I saw h.. alive on Aug 23 1921, and that death occurred, on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis

(Duration) ....yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) A. Lee Ellis M. D.

8/24/, 1921 (Address) 924 Mad Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Aug 26, 1921.

20-UNDERTAKER Daniel Carbon

ADDRESS 916 Pine

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D 56406

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 56406

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. James L. Kernan Hospital St. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Edith May Miller

(Residence in Baltimore: No. 1715 Byrd St St.: 10 yrs. 10 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6 DATE OF BIRTH October 8, 1910 (Month) (Day) (Year)

7 AGE 10 yrs. 10 mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Robert E. Miller

11 BIRTHPLACE OF FATHER (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Ada E. Spurry

13 BIRTHPLACE OF MOTHER (State or country) Talbot Co, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert E. Spurry

(Address) 1715 Byrd St

15. Filed AUG 25 1921 19.. ROBERT J. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 23 (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 17, 1918, to Aug 23 1921, that I saw h[er] alive on Aug 23, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis

Bilateral

(Duration) 1 yrs. 7 mos. 10 ds.

Contributory (SECONDARY) Tuberculosis of Epiglottis

(Duration) 3 yrs. 6 mos. 15 ds.

(Signed) William H. Daniels M. D.

Aug 23, 1921 (Address) 1107 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death 3 yrs. 6 mos. 6 ds. In the State 10 yrs. 10 mos. 13 ds.

Where was disease contracted, if not at place of death? 1715 Byrd St Balto

Former or usual residence 1715 Byrd St Balto

19 PLACE OF BURIAL OR REMOVAL Cedar Hill Cem — DATE OF BURIAL 8/26, 1921

20 UNDERTAKER L. Fenwick McCarthy — ADDRESS 130 E. Fort

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHRASING state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56407

CERTIFICATE OF DEATH.

151 D 56407

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Aisquith St. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas. A. Ernst

(a) RESIDENCE. NO. 902 Aisquith St. ST. 10 WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 9. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Ernst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungaria

12 MAIDEN NAME OF MOTHER Mary Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungaria

14 Informant Mr. Thomas Ernst
(Address) 902 Aisquith St

15 Filed AUG 25 1921, 19.. Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24. 1921

17 I HEREBY CERTIFY, That I attended deceased from July 4. 1921, to Aug. 24. 1921, that I last saw him alive on Aug. 24. 1921, and that death occurred, on the date stated above, at 9 A. M. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility
Marasmus

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Congenital Debility

(duration) yrs. 9 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) E. J. Lebal, M. D.

, 19 (Address) 1001 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 26 1921
20 UNDERTAKER	ADDRESS
Henry Storck & Son	1301 E Eager St.

Mutilation should be avoided, so that it may be properly classified. Exact information CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56408

CERTIFICATE OF DEATH.

101 D 56408

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.....

CITY OF BALTIMORE: No. ..... St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara P Blanchard

(a) RESIDENCE. No. ..... Hebrew Hospital ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry P Blanchard

6 DATE OF BIRTH (month, day, and year) March 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	5.	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address) Hebrew Hospital

15 Filed AUG 25 1921 — 19 — [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1921, to Aug 24, 1921, that I last saw her alive on 8/24, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows: OVER

Arthritis due to

Time unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Advanced age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris Paulson, M. D.

, 19 (Address) Hebrew Hospital. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew Cem	8/26 1921
20 UNDERTAKER L Goodheim 118 Mont	ADDRESS Royal Ave

mation should be carefully supplied, so that it may be properly classified. Each question must be answered or the word "unknown" or the abbreviation "unk." inserted. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered or the word "unknown" or the abbreviation "unk." inserted. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should he used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may he entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at heginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Heart failure.
Starvation. No further
history.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56409

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56409

CERTIFICATE OF DEATH.

92

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 E. 20½ St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Thompson

(Residence in Baltimore: No. 302 E 20½ St. 81 St.; unknown yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	Col	Married

6-DATE OF BIRTH. ....., 1858
(Month) (Day) (Year)

7-AGE. 63 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Janitor G.P.O.
(b) General nature of industry, business, or establishment in which employed (or employer): Janitor

9-BIRTHPLACE. (State or Country). St Marys Co. Md

PARENTS.

10-NAME OF FATHER. Edward Thompson

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Thompson Son

(Address) 142 N. Fulton

15- AUG 25 1921 ROBERT A KRAUSE
Filed....., 191.... Registrar.
Burial Permit

N.B. ENTIRE CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. ....Aug..... 23, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1921, to Aug 23 1921, that I saw him alive on Aug 22nd 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) C. J. Graham M. D.

Aug 23, 1921. (Address) 2413 Pennsylvania Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Given Cemetery	Aug 25, 1921.
20-UNDERTAKER Robert A Elliott	ADDRESS 1725 Ashland Ave

Lobar. No hemorrhage. Not cyclic.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56410

D 56410

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Biddle & Selleman Sanatorium ST.: WARD)

2-FULL NAME George W. Mann.

(a) RESIDENCE. NO. Bellerton. Md. ST.. WARD. Bellerton Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora B. Mann

6 DATE OF BIRTH (month, day, and year) July 28 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	-	25 -	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cars

(b) General nature of Industry, business, or establishment in which employed (or employer) Mfg

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Still Pond Md

PARENTS

10 NAME OF FATHER George R. Mann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Permil L. Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Salto Md

14 Informant Mrs Arthur J. Cadwalader (Address) 4116 N. Broadway

15 Filed AUG 25 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23- 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8 - 1921. (to) Aug. 23 - 1921.

that I last saw him alive on Aug. 23 - 1921.

and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. mos. ds.

Mitral Insufficiency some

18 Where was disease contracted if not at place of death? Bellerton, Md.

Did an operation precede death? — Date of

Was there an autopsy? no -

What test confirmed diagnosis?

(Signed) J. Baird Brewer. M. D.

. 19 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Md — DATE OF BURIAL Aug 26 1921

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W. North Ave

Burial Permit Clerk

mation should be carefully supplied. [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56411 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56411

CERTIFICATE OF DEATH. 120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3708 Falls Rd ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Obrien

(a) RESIDENCE. NO. 3708 Falls Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow Geo Obrien

6 DATE OF BIRTH (month, day, and year): March 24 1844

7 AGE — Years: 77 Months: 5 Days:

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Fanny E Heath
(Address) 3708 Falls Road

15 Filed AUG 25 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1921, to Aug 24, 1921, that I last saw her alive on Aug 23, 1921, and that death occurred, on the date stated above, at 1400 m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 37 ds.

CONTRIBUTORY (Secondary) Chronic Interstinal Nephritis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A J Danes, M. D.

8/24 1921 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Aug 26 1921

20 UNDERTAKER: J W Cutsail & Nattan — ADDRESS

N. B.—Information should be carefully supplied. Accurate answers to all questions will help that it may be properly classified. Exact answers to CAUSE OF DEATH in plain terms, so that it may be understood by others than physicians, are necessary. Omissions will delay issue of certificates. See instructions on back of certificate. TION is very important.

Spec. 6-9-13 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43-021 3 D 56412 104 56412

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Knowles

a) RESIDENCE. NO. 1 Rodenwood Rd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 7 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Raymond Holt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lorraine Knowles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Johns Hop. Kins Hospital (Address) Records

15 Filed AUG 25 1921 . 19 ROBERT J. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 21 . 1921, to Aug 22 . 1921, that I last saw h[illegible] alive on Aug 22 . 1921, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhea not dysentery

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? None

(Signed) W. Davison, M. D.

19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	Aug 24th 1921
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF RESIDENCE is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Information received from Child Hygiene child born St University Hospt.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56413 — 120 — D 56413

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Harry V Hecker ST.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 2327 Greenmount ave

(Residence in Baltimore: No. 2327 Greenmount Ave St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dec 23, 1870
(Month) (Day) (Year)

7-AGE, 45 yrs. 8 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Wagons

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John C Hecker

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Annie M Brown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Hecker

(Address) 2327 Greenmount

15- AUG 25 1921 ROBERT J. KRAUTER

Filed ....., 191.... Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 17 1921, to Aug 23 1921, that I saw him alive on Aug 23 1921, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Constitutional Nephritis

(Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) L W Sudders M. D.

Aug 24, 1921. (Address) 321 E 25

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Aug 26 1921.
20-UNDERTAKER	ADDRESS
E. G. Windfield	501 E 22

N.B.—Every item of information should be given as far as possible. Also particularly classified. Also particularly CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D 56414

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56414

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Standard Guano Company, Curtis Bay. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeremiah Griffin.(C)

(Residence in Baltimore: No. 231 Pearl St. St.; yrs. 40 mos. --- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored	Widower

6-DATE OF BIRTH, Do not know. (Month) (Day), 1861 (Year)

7-AGE, 55 yrs. ---- mos. ---- ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Buddie Griffin (C)

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Harriet. ---- ------

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Griffin.(C) son.

(Address) 669 Bradley St.

15- Filed AUG 25 1921, 191.... ROBERT A KRAUTER Registrar. Burial Permit ....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 20th. 1921 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. H. Reinhardt M. D. (Coroner.)

Aug. 25., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Aug 25 1921

20-UNDERTAKER Daniel Beasley ADDRESS 1825 E Baltimore

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Mary S. Delorme

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56415

CERTIFICATE OF DEATH.

172 D 56415

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Little Sisters of Poor 10 St.; WARD)
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Seraphine.

(Residence in Baltimore—No. Little Sisters of Poor St.) (yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb. 8th, 1862.
(Month) (Day) (Year)

7-AGE. 59 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Sister 16 Years
(b) General nature of industry, business, or establishment in which employed (or employer). Catholic

9-BIRTHPLACE, (State or Country), France.

PARENTS.

10-NAME OF FATHER, Charles Delorme

11-BIRTHPLACE OF FATHER (State or Country), France

12-MAIDEN NAME OF MOTHER Francoise Berger

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister F. Lorence

(Address) Little Sisters of the Poor

15- ROBERT J. KRAUTER
Filed AUG 25 1921 191... Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 23, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Fulminant

Duration 2 days

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Aug. 25, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs...mos...ds. In the State ...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral	Aug. 26, 1921.
20-UNDERTAKER	ADDRESS
H. C. Wadsfield	94 Greenmount Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 63-001 D 56416

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 ~~Fremont~~ St.: 20th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Meyers.

(a) RESIDENCE. No. New York City St. 20th WARD. New York City

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Nov 24 = 1919

7 AGE: Years — Months 9 Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Conrad Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore - Md

12 MAIDEN NAME OF MOTHER: Hattie Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Conrad Meyer (Address) 426 Fremont St

15 Filed AUG 25 1921 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 24 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21 1921, to Aug. 24 1921, that I last saw h.er alive on Aug. 24 1921, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral (Anterior Poliomyelitis)

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary): None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Probably in N. Y. City

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Nathan B Bordentsky, M. D.

. 19 (Address) 2114 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Aug 25th 1921

20 UNDERTAKER: F B Keppert — ADDRESS: 2336 Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56417 CERTIFICATE OF DEATH. 104 D 56417

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Lusby

(a) RESIDENCE. NO. 2034 E Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sparrows Point Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Lusby

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Pearle McNorman

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant
(Address)

15 Filed ..., 19.. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/23 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/19, 1921, to 8/23, 1921.

that I last saw him alive on 8/23, 1921.

and that death occurred, on the date stated above, at 10.05 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

(duration) yrs. mos. 1 day

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [signature], M. D.

, 19 (Address) 2401 Fairfax Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

AUG 25 1921

AUG 25 1921

Commissioner of Health

Information should be carefully supplied. Each question must be properly classified. Exact statements are required. Read CAUSE OF DEATH in plain terms, so that it may be properly classified. Read instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56418

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56418

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Greenmount ave ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elwood J. Harmon.

(a) RESIDENCE. No. 820 Greenmount Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 11th 1887

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
34	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer James. H. Harmon

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James. H. Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Ida M. Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ida M. Harmon

(Address) 820 Greenmount Ave.

15 DATE RECEIVED AUG 25 1921

ROBERT J. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to Aug 23, 1921, that I last saw him alive on Aug 22, 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Adenitis carcinoma Liver, with Portal Stasis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 844 Greenmount Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Boulton M. D.

1924 (Address) 700 E Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	Aug 25th 1921
20 UNDERTAKER	ADDRESS
Leo G. Cook	Northbridge Mass

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56419

D 56419

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 E. Lafayette Ave.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Divis Thompson

(a) RESIDENCE. No. 1927 E. Lafayette Ave St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer, Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0486

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Denbrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Florence Thompson (Address) 1927 E. Lafayette Ave.

15 Filed AUG 25 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1921

17 I HEREBY CERTIFY, That I attended deceased from April 10th, 1921, to Aug 23rd, 1921, that I last saw h[illegible] alive on Aug 23rd, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation and pericardial effusion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George L. Ross, M. D.

. 19 (Address) 2409 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Carroll Co Md	Aug 26 192
UNDERTAKER	ADDRESS
W. Shriver & Son	Towson

mation should be carefully supplied. Blanks must be properly classified. Data must be complete.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Indefinite terms and abbreviations must not be used. Name of contagious disease, if any, must be given.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56420 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 104 D 56420

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Union ave ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME alverda E. Heng

(a) RESIDENCE NO. 1009 Union ave ST., Mount Park WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10 Mos

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1920	Oct	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Fredrick Heng

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER agnes Ensor

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant (Address) Agnes Heng 1009 Union st

15 Filed ..... 19 Robert F. Harrison, Burial Permit Clerk. Registrar

AUG 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24 1921

17

I HEREBY CERTIFY, That I attended deceased from 8-20- , 1921 , to 8-24 , 1921 ,

that I last saw h alive on 8-24 , 1921 ,

and that death occurred, on the date stated above, at 11.55- P. m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) yrs. mos 2 mos ds.

CONTRIBUTORY (Secondary) enteric Colitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos B Hall, M. D.

, 19 (Address) Holabird

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Aug 26 1921

20 UNDERTAKER John J Falls ADDRESS 700 W Fayette ave

B.—WRITE plainly. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. INFORMATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56421

CERTIFICATE OF DEATH.

120 D 56421

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 E. Oxford St. 23 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr Nicholas Pfister

(Residence in Baltimore: No. 23 E. Oxford St.: Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 25, 1854
(Month) (Day) (Year)

7-AGE, 67 yrs. 4 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Police Officer
(b) General nature of industry, business, or establishment in which employed (or employer): 061

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Ferdinand Pfister

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret L

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Pfister

(Address) 73 E. Oxford St.

15-

Filed ..... Robert P. Harrison, Registrar.

AUG 25 1921 Burial Permit Clerk.

N. B.—Every item of information must be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 23, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 13 1921, to Aug 23 1921, that I saw h[illegible] alive on Aug 20 1921, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

General Nervous Breakdown Co.

Chronic Bright's Disease

(Duration) .....yrs. .....mos. 1 4 ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease

(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) Lee Starks M. D.

....., 191... (Address) 3 E. St. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. DATE OF BURIAL, Aug 26, 1921

20-UNDERTAKER Margaret D. Flynn ADDRESS 1477 Light St.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 56422

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56422

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Nitski

(a) RESIDENCE. NO. None ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed AUG 25 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24 1921

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to August 24, 1921, that I last saw him alive on August 23, 1921, and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Def Nephritis,

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

8/24/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	aug 26 1921

20 UNDERTAKER John M. Weber ADDRESS 1803 Bank St

mation should be entered, supplied. Exact statements CAUSE OF DEATH in plain terms, so that it may be p TION is very important. See instructions on back of cer

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56423

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56423

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 Lowman ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oswald H. Hansen

(a) RESIDENCE. No. 1405 Lowman ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
White	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry W. Hansen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Julia Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica B. W. I.

14 Informant Julia Hanson (Address) 1405 Lowman St

15 Filed . 19 Robert P. Harrison, Registrar

G 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24. 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 14 1921, to Aug. 24 1921, that I last saw h-im alive on Aug 24 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal Intoxication

(duration) yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Pertussis (Whooping Cough)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. E. Marr, M. D.

8-25-1921 (Address) 827 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A. A. Co	Aug 26 1921

20 UNDERTAKER A. Jones ADDRESS 207 S. Stricker St

be properly classified. Attention is called to the importance that this information should be carefully supplied. All items must be answered or the words "unknown" or "none" inserted, as the case may be. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements are required. See Section 12 of Regulations governing the registration of births, deaths and burial permits. TION is very important. See instructions on back of certificates.

Clough

D 56424 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56424

CERTIFICATE OF DEATH.

REGISTERED NO. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1806 E. Hopkins ST. Monument WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Clough.

(Residence in Baltimore: No. 1806 E. monument St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Wh.	Single

6-DATE OF BIRTH, April 13, 1898
(Month) (Day) (Year)

7-AGE, 23 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Oil Teller
(b) General nature of industry, business, or establishment in which employed (or employer)..... Co

9-BIRTHPLACE. (State or Country), Va.

PARENTS.

10-NAME OF FATHER, J. Clough.

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Rosa Ruby,

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. P. Clough

(Address) 2813 E. Monument

15- Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

JE 25 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24, 1914
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns: gas + flame
Exhaustion
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)
6-23, 1914 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Easton, Md.	Aug 26 1914
20-UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56425

D 56425

CERTIFICATE OF DEATH.

H 12

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2319 Hayford ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josphine Kaufmann.

(a) RESIDENCE. NO. 2319 Hayford ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~ Widowed, or ~~Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Theodor Kaufmann

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE: 69 (Years / Months / Days / If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balt md

PARENTS

10 NAME OF FATHER: Jacob Kremer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany md

12 MAIDEN NAME OF MOTHER: Josphine Kremer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs E Dersch (Address) 2319 Hayford ave

15 Filed AUG 26 1921 [illegible] KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 23. 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 23, 1921, that I last saw h.. alive on Aug 23, 1921, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Probably originated in uterus

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Jones M. D.

Aug 23 1921 (Address) 4106 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer Cem. | DATE OF BURIAL: Aug. 27 1921

20 UNDERTAKER: George J. Ruth | ADDRESS: 1735 Hayford ave.

mation should be carefully
CAUSE OF DEATH in plain ter
TION is very important. See instructions on ba

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56426

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Franklin

(a) RESIDENCE. NO. 6 Earl Court Apt ST., WARD. St James R. 6

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy Franklin

6 DATE OF BIRTH (month, day, and year) July 4 th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Henry K. Franklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond

12 MAIDEN NAME OF MOTHER Dorothy Leslie Ronake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Henry K. Franklin Earl Court. apartment

15 Filed AUG 20 1921 [illegible] Registrar

Burial Form 1 Black

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1921, to Aug 24, 1921, that I last saw h[illegible] alive on Aug 24, 1921, and that death occurred, on the date stated above, at 7.25 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis and Cardiac Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank C Manna M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond. Va.

DATE OF BURIAL Aug 26 1921

20 UNDERTAKER [illegible] - L. Ruth

ADDRESS 1735 Harford ave.

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56427

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

REGISTERED NO. C 56427

CITY OF BALTIMORE: (No. 2411 Eutaw St Married pl 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C Jones

(Residence in Baltimore: No. 2411 Eutaw Married pl St.; 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, Feb (Month) 23 (Day) 1880 (Year)

7-AGE, 41 yrs. 7 mos. 28 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Edmund Belcher

11-BIRTHPLACE OF FATHER (State or Country), md.

12-MAIDEN NAME OF MOTHER Sophie Bernhusel

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William L Jones

(Address) 2411 Eutaw St

15- Filed AUG 26 1921, 191.... ROBERT J. BRUTTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Aug (Day) 25 (Year) 1921.

17. I HEREBY CERTIFY, That I attended deceased from July 24 1921, to Aug 25 1921, that I saw h[illegible] alive on Aug 23 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ?

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Reginald W. Hearn M. D.

Aug 27, 1921 (Address) Catonsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount	Aug 28 1921
20-UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

N. B.—Every item of information must be properly established. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56428

CERTIFICATE OF DEATH.

19 D 56428

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3rd & Greenmount Ave ST.; 12th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza. Wilson

(Residence in Baltimore: No. 403 - E. 23 St 30 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1874 (Year)

7-AGE 47 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070

9-BIRTHPLACE, (State or Country) Dallas Co. Ind

PARENTS.

10-NAME OF FATHER, Terry Harding

11-BIRTHPLACE OF FATHER (State or Country) Dallas Co Ind

12-MAIDEN NAME OF MOTHER Harriett Rudasson

13-BIRTHPLACE OF MOTHER (State or Country). Dallas Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ozella Gantt

(Address) 403 E. 23rd Street

15- AUG 26 1921 ROBT. J. KRAUTH

Filed ....., 191 Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or inquiry) thereon and from the evidence obtained by said Inquest and ..... find that said deceased came to ..... death on the day stated above. (Autopsy or inquiry)

The CAUSE OF DEATH* was as follows:

Valvular disease of heart.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison M. D.

(Address) 2632 Rolandave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Laurel Penn — DATE OF BURIAL, Aug 26 1921

20-UNDERTAKER Edward Wensley — ADDRESS Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56429 56429

CERTIFICATE OF DEATH.

45

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 Pierce ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Welch Jr

(a) RESIDENCE. NO. 934 Pierce ST., 18 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 2-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Soldier

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Welch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co

12 MAIDEN NAME OF MOTHER Elizabeth Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Robert Welch

(Address) 934 Pierce St

15 Filed ..... 19 ROBERT A. KRAUTER Registrar

Burial Permit Clerk

AUG 26 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov-18 1920, to Aug 23 1921

that I last saw h... alive on Aug 23 1921

and that death occurred, on the date stated above, at 8:10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of Knee

(duration) 1 yrs. 9 mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Clinical Signs

What test confirmed diagnosis?

(Signed) Walter J. Jackson, M. D.

..... 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Federal Cemetery	8/26 19
20 UNDERTAKER	ADDRESS
Geo. H. Hooper & Co	406 W. Lanvale St

N. B.—All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56430 ✓ 56430

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1837 N.Bond St ,, ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia A.Carter,

(a) RESIDENCE. NO. 1837 N.Bond St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25th. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm.Carter,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland,

12 MAIDEN NAME OF MOTHER Elizabeth Dempse[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland,

14 Informant Harry Carter,
(Address) 1837 N.Bond

15 Filed ..., 19 ...
[illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug - 24 1921

17 I HEREBY CERTIFY, That I attended deceased from May 18 1921, to Aug 24 1921, that I last saw her alive on Aug 24 1921, and that death occurred, on the date stated above, at 9-30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E-Gill Hall, M. D.

Aug. 23 1921 (Address) 1617 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	8/27 1921
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	1810 Bond & Royal Ave

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56431

REGISTERED NO. 114 D 56431

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto General Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Levy

(a) RESIDENCE. No. 603 Argyle ST., Balto WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Levy

6 DATE OF BIRTH (month, day, and year) unknown 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Yusa Klein
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Mary —
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1411 E Balto St

15 Filed AUG 26 1921 [illegible] Registrar
Burial Permit Dist

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from August 22, 1921, to August 26, 1921, that I last saw her alive on August 26, 1921, and that death occurred, on the date stated above, at 9 4 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Post Operative)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cholelithiasis & Pelvic Cellulitis

(duration) yrs. mos. 3 weeks ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Aug. 23 1921.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) James Hubert Wilkerson, M. D.

, 19 (Address) South Balto General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	8/26 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto St

mation should be carefully supplied. Are answers
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56432

CERTIFICATE OF DEATH.

50 D 56432

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hosp' ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J Fitzsimmons

(Residence in Baltimore: No. 238 London Ave St.; 59 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, March (Month) 25th (Day), 1862 (Year)

7-AGE, 59 yrs. 5 mos. 0 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Superintendent of Bakers at Baltimore City Jail
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, James Fitzsimmons

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Reynolds

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Bridget A. Fitzsimmons
(Address) 238 Loudon Ave.

15- Filed AUG 26 1921, 191... ROBERT J. KRAUTER Clerk. Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 25, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug-25 1921, to Aug 25 1921, that I saw h.im alive on Aug 25 1921, and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
Chr. Nephritis & Hypertension (?)
(Duration) ..... yrs. 5 mos. ..... ds.
CONTRIBUTORY (Secondary) Diabetic Coma
(Duration) ..... yrs. 30 hrs. mos. ..... ds.
(Signed) L. Lloyd Johnson M. D.
Aug-25, 1921 (Address) Bon Secours Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Pleasant Cemetery — DATE OF BURIAL, Aug. 29, 1921

20-UNDERTAKER Joseph B. Cook — ADDRESS 1003 W. Balto St.

N. B.—Every item must be answered in plain terms, so that it may be properly classified. Especially must CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56433

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1755 W. Lexington ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lulu M. Belt

(a) RESIDENCE. NO. 1755 W. Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phillip C. Belt

6 DATE OF BIRTH (month, day, and year) Dec 5, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co. Md.

PARENTS

10 NAME OF FATHER Alexander Hedden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth C. Hedden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Phillip C. Belt 1955 W. Lexington St.

15 Filed AUG 26 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to Aug 25, 1921, that I last saw h[illegible] alive on Aug 25, 1921, and that death occurred, on the date stated above, at 9.05 a. m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lyman S. Abbott, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Aug 27 1921

20 UNDERTAKER: John C. Mitchell — ADDRESS: 120 W. Fayette St.

Information should be carefully supplied. Any statement of doubtful accuracy should be so stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. This information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56434

CERTIFICATE OF DEATH.

40 D 56434

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (NO. 1514 Division ST. 28 Hennighausen WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Percy Hennighausen

(a) RESIDENCE. NO. Tan Hills, Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Lizzie Hennighausen

6 DATE OF BIRTH (month, day, and year) June 26th, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Frederich Hennighausen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Sopley

13-BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Frederick H. Hennighausen (Address) Osborne Apts Catonsville

15 Filed ..... 19 ..... Robert F. Harrison, Registrar Burial Permit Clerk.

AUG 26 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from August 20th, 19 21, to August 25th, 19 21, that I last saw him alive on August 25th, 19 21, and that death occurred, on the date stated above, at 10 07 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Liver and Retro-peritoneal glands. (Primary focus undetermined.)

(duration) yrs. 4 mos. (?) ds.

CONTRIBUTORY (Secondary) Secondary haemorrhage into peritoneal cavity (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of August 22nd, 1921.

Was there an autopsy? Partial.

What test confirmed diagnosis? Operation & autopsy.

(Signed) Jno. H. Hunner Jr., M. D.

Aug 25th 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Aug 29 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1708 W. Fayette

mation should be carefully supplied. Avoid abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 56435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

105

D 56435

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 211 S. Bethel St. ST. 3 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2 FULL NAME Robert Covell

(Residence in Baltimore: No. 211 S. Bethel St. St.: yrs. 11 mos. 4 ds.) 7

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Colored	Single

6 DATE OF BIRTH March 17, 1910 (Month) (Day) (Year)

7 AGE 11 yrs. 4 mos. 7 ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none 600
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore City. Md.

PARENTS

10 NAME OF FATHER Albert Covell.

11 BIRTHPLACE OF FATHER (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Annie Morgan.

13 BIRTHPLACE OF MOTHER (State or country) Baltimore, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ethel Covell

(Address) 211 S. Bethel St

15 [illegible] Harrison, Robert E. Harrison, Burial Permit Clerk

Filed ..... 191[illegible]

AUG 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 24, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 22, 1921, to August 23 1921, that I saw him alive on August 23, 1921, and that death occurred, on the date stated above, at 2. a. m.
The CAUSE OF DEATH* was as follows:

Acute Enteritis.
(caused by ingesting some bitter tasting poison)
(Duration) 4 yrs. 4 mos. 5 ds

Contributory (SECONDARY) Exhaustion
(Duration) 1 yrs. 4 mos. 2 ds.

(Signed) Frederick G. Huener M. D.
August 24 1921 (Address) 112 S. Broadway.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt. Auburn — DATE OF BURIAL Aug 27 1921

20 UNDERTAKER Harry A. Vodery — ADDRESS 1725 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56436

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56436

CERTIFICATE OF DEATH.

X 37

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Camp Holabird Md ST.: No WARD)

2-FULL NAME Patrick J. Kelly

(a) RESIDENCE. NO. Fort Howard Md ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ——— yrs. ——— mos. ——— ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ———

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	22	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soldier 086

(b) General nature of Industry, business, or establishment in which employed (or employer) Pvt U.S. Army

(c) Name of employer U.S. Govt.

9 BIRTHPLACE (city or town) (State or country) Waterbury Conn.

PARENTS

10 NAME OF FATHER Martin Kelly

11 BIRTHPLACE OF FATHER (city or town) ———
(State or country)

12 MAIDEN NAME OF MOTHER ———

13 BIRTHPLACE OF MOTHER (city or town) ———
(State or country)

14 Informant C W Fales
(Address) Camp Howard Md

15 Filed AUG 26 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1921

17 I HEREBY CERTIFY, That I attended deceased from July 25 1921, to Aug 25 1921, that I last saw him alive on Aug 25 1921, and that death occurred, on the date stated above, at 8 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Syphilis

(duration) ——— yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) None

(duration) ——— yrs. ——— mos. ——— ds.

18 Where was disease contracted if not at place of death? Fort Howard

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? Pat Sunday + Friday

(Signed) H Power C W Fales, M. D.

, 19 (Address) Camp Holabird Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Waterbury Conn.	Aug 26 1921
20 UNDERTAKER Sol Levinson	ADDRESS 421 E Baltimore St

mation should be carefully supplied. Any [illegible] it may be properly classified. Exact statements of
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

Spec.—6-9-15—H. P. Co.—1000 Blks.

D 56437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56437

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Proctor

(a) RESIDENCE. NO. 100 N. Caroline st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Robert Proctor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Atchison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records M. T. Harrison, Robert T. Harrison,

15 Filed 19 Burial Permit Clerk. Registrar

AUG 26 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1921, to Aug. 25, 1921, that I last saw him alive on Aug. 25, 1921, and that death occurred, on the date stated above, at 11.50 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Balogliacca M. D.

8-26-21. (Address) Municipal St Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 29 1921

20 UNDERTAKER: Wilson Co 1/6 — ADDRESS: 502 E Mad St

mation should be carefully supplied. Exact statement of [illegible] may be properly classified. CAUSE OF DEATH in plain terms, so that it may [illegible] TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56438

CERTIFICATE OF DEATH.

92 D 56438

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2717 Harlem ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. H. Speddeen

(a) RESIDENCE NO. 2717 Harlem ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Lydia E. Speddeen

6 DATE OF BIRTH (month, day, and year) Oct 16-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Commission Merch.

(b) General nature of Industry, business, or establishment in which employed (or employer) OHS

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Speddeen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Speddeen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lydia E. Speddeen

(Address) 2717 Harlem Ave

15 Filed AUG 26 1921, 19 ..... Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 21st 1921 19 . to Aug 25 . 1921 .

that I last saw him alive on Aug 24th . 1921 .

and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, (Hypostatic)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) General Debility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Henry B Wolb M. D.

Aug 25 1921 (Address) 703 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Aug 29 1921
20 UNDERTAKER	ADDRESS
Wilson Co's	502 E Wood

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Lanham
718 N Patterson Pk

D 56439

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 56439

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 North Milton Ave. 16 WARD)

2-FULL NAME Henry W. Gertz

(a) RESIDENCE NO. 735 North Milton Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna M. Gertz

6 DATE OF BIRTH (month, day, and year) Dec 11

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Gertz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wolfkowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edgar H. Gertz

(Address) 735 North Milton Ave

15 Filed AUG 26 1921 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1921, to Aug 24, 1921, that I last saw him alive on Aug 23, 1921, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) A. J. Lenhart M. D.

(Address) 718 N. Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem

DATE OF BURIAL Aug 27 1921

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. AGE mation should be carefully supplied. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56440

CERTIFICATE OF DEATH.

104 D 56440

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2123 Mura ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thornton Thomas

(a) RESIDENCE. No. 2123 Mura ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | COLOR OR RACE: White | 4 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24

7 AGE — Years: 5 | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): Not

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Pte Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Rosa E Bibb

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Rosa E Thomas
(Address): 2123 Mura St

15 Filed: Robert F Harrison Registrar
AUG 25 1921
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1921, to Aug. 25, 1921, that I last saw him alive on Aug 21, 1921, and that death occurred, on the date stated above, at 9.50 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Contributory Malnutrition

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Albert L. Fraser M. D.

Aug 24 1921 (Address) 1031 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery | DATE OF BURIAL: Aug 25 19

20 UNDERTAKER: Wm Cook & Son | ADDRESS: Balto

mation should be carefully supplied. Any abbreviations may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Intestinal
Trouble cause of
Malnutrition

Spec.—1-10-21—M&T—1500 Blks.

D 56441

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D 56441

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Glenmore av near Woodlyn Ave ST., 27 WARD)

2-FULL NAME Sarah Kelly

(a) RESIDENCE NO. Glenmore ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles P Kelly

6 DATE OF BIRTH (month, day, and year) apr 23-1832

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	89	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ppp

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Henry Rowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER dont Kenow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Catherine Kelly
(Address) 27 Glenmore Ave

15 Filed AUG 26 1927, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1927, to Aug 25, 1927, that I last saw h alive on Aug 24 1927, and that death occurred, on the date stated above at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of Dead

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis L Lewis M. D.

(Address) 27 Harford Rd. Aug 25 1927

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cem. (Govans) DATE OF BURIAL Aug 29 1927

20 UNDERTAKER F. A. Tenuse & Son ADDRESS 703 Harford Ave

N. B.—WARNING—This certificate should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 56442

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56442

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 569 Lawrence ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Meyberger

(a) RESIDENCE. No. 569 Laurence ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Cigars

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Philip Meyberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Emma Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Boland

(Address) 554 Lawrence St.

15 Filed ..... 19 ..... Registrar

Robert F. Harrison,

AUG 25 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25-1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1921, to Aug 25, 1921, that I last saw h alive on Aug 24, 1921 and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chr. Organic Heart Disease (duration) 2 yrs. mos. ds.

Myocarditis

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James Brown M. D.

8/26/1921 (Address) 837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 27 1921
20 UNDERTAKER Martin Fahey Sons	ADDRESS 1727 W North

mation should be carefully supplied. Age should be given in years, months and days. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56443

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1271 Sargeant ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry A. Stricker

(a) RESIDENCE. NO. 1271 Sargeant ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Charles H. Stricker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Martinsburg W Va

12 MAIDEN NAME OF MOTHER Maggie V. Lemmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Charles H. Stricker
(Address) 1271 Sargeant St.

15 Filed Robert F. Harrison, Registrar
AUG 26 1921 Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS and others should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1921, to Aug 25, 1921, that I last saw h in alive on Aug 24, 1921, and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. L. McCliffen, M. D.

Aug 26, 1921 (Address) Monree Park Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Aug 27 1921
20 UNDERTAKER	ADDRESS
Mr. & Mrs. John W. Gemfel & Son	801 N. Fayette

(Buccheri)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56444

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56444

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5th Ave near 35th St. 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Giuseppe Buccheri

(a) RESIDENCE. NO. 5th Ave near 35th St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Giuseppe Disabato

6 DATE OF BIRTH (month, day, and year) Dec. 13 - 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Gaetano Buccheri

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosalia di Liberto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

11 Informant (Address) Gaetano Buccheri 5th ave & 35th St.

15 Filed AUG 26 1921 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1918, to Aug 24, 1921, that I last saw h[illegible] alive on Aug 26, 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Pt Hemiplegia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion 2 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Amby L. Clinton, M. D.

, 19 (Address) 105 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: 8/29/21

20 UNDERTAKER: Geo. J. Ruth ADDRESS: 1730 Harford

N. B.—WRITE PLAINLY. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56445

CERTIFICATE OF DEATH.

X 64

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ..... St.: 14 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Frank P. Smithson

(a) RESIDENCE. No. Forest Hill, Md, St., Ward. (Forest Hill Harford Co. Md)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Priscilla F. Smithson

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 054

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER George Smithson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Records at Hospital (Address) Baltimore.

AUG 26 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1921, to Aug 26, 1921, that I last saw him alive on Aug 26, 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Ulcer of Pylorus

Cholelithiasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia and Cerebral Hemorrhage (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/22/21

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation & Clinical

(Signed) George E. W. Hardy, M. D.

19 Address Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Spring - Harford Co. Md

DATE OF BURIAL Aug 28 1921

20 UNDERTAKER STEWART & [illegible] COMPANY

(WILLIAM P. [illegible])

ADDRESS [illegible] NORTH AVE.

N. B.—WRITE PLAINLY, WITH INK. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. Information as it may be properly classified. Exact statement of OCCUPATION of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56446

CERTIFICATE OF DEATH.

40 D 56446

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 Spruce ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Glowacki

(a) RESIDENCE. No. 2015 Spruce ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? 35 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown,

6 DATE OF BIRTH (month, day, and year) Jan. — 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired, Ol

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany,

PARENTS

10 NAME OF FATHER Michal Glowacki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Casimir Glowacki
(Address) 2015 Spruce St

15 Filed AUG 26 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1921, to Aug 24, 1921, that I last saw him alive on Aug 24, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of stomach.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Phantom

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? X ray

(Signed) Edward Engel, M. D.

8/26, 1921 (Address) 707 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Aug 27, 1921

20 UNDERTAKER Wm Piaskowski

ADDRESS 1618 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56447

D 56447

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1607 Grace Court ST. 175 WARD)

2-FULL NAME Alfreda F. Demetro

(a) RESIDENCE. NO. 1507 Grace Court ST. Curtis Bay WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 1 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
		1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Demetro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Frances Podlesny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Thomas. Demetro
(Address) 1507 Grace Court Curtis Bay

15 Filed Aug 29 1921 Robert P. Harrison, Registrar

16 Burial Permit Clerk

AUG 26 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1921, to Aug. 26, 1921, that I last saw her alive on Aug. 25, 1921, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Goiter & Uremia.

(duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) William H. Lerch M. D.

, 19 (Address) 816 - Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Dale	Aug 29 1921

20 UNDERTAKER Wm Fairbanks

ADDRESS Eastern Ave.

W. 5 14

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56443

28 D 56448

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 E. Lafayette ave ST., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Schweizer

(a) RESIDENCE NO. 1721 E. Lafayette ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of [redacted] Octavia Schweizer

6 DATE OF BIRTH (month, day, and year) March 16th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) 1615

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Schweizer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Octavia Schweizer (Address) 1721 E Lafayette ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

AUG 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Several years ago 19..... to Aug 25 .1921.

that I last saw h[illegible] alive on Aug 25 .1921

and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Several yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marie L. Deegan M. D.

8/26. 1921 (Address) 2439 St Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cem	Aug 29 1921

20 UNDERTAKER ADDRESS

Chenoweth & Son Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S name should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Winifred M. Bartlett

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56449

CERTIFICATE OF DEATH.

14th

D 56449

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs John Bartlett

(a) RESIDENCE. No. 214 Roland Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John Bartlett

6 DATE OF BIRTH (month, day, and year) Jan 16 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Gilron

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Anne Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mr John F. Bartlett (Address) 214 Roland Ave

15 Filed AUG 27 1921 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1921, to Aug 26, 1921, that I last saw h~~im~~ alive on Aug 26, 1921, and that death occurred, on the date stated above, at 2:30 A.m.

The CAUSE OF DEATH* was as follows:

Retroperitoneal Abscess

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema and Hypostatic Congestion (duration) yrs. mos. Two hours ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/11/21 & 8/22/21

Was there an autopsy? No.

What test confirmed diagnosis? Operations.

(Signed) George C. Hardy M. D.

19 (Address) Mercy Maternity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	August 27 1921
20 UNDERTAKER Henry A. Jenkins & Son Co	ADDRESS Oliver & Fayette Sts

S. B.—WRITE PLAINLY. Without erasures or interlineations. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56450

HEALTH DEPARTMENT—CITY OF BALTIMORE

40

D 56450

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 S. Linwood Ave ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Smith

(a) RESIDENCE NO. 812 S. Linwood Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor 086

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 30 years

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Georgl Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mathilda Holthaus

(Address) 812 S. Linwood ave

15 Filed AUG 27 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2 1921 to Aug 24 1921, that I last saw h— alive on Aug 24 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) General debility

(duration) — yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dr. C. Bowers, M. D.

27/6/1924 (Address) 1255 S Bdwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Aug. 27 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. INFORMATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of deceased should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56451 — 70 — D 56451

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1244 Spring (Morrell Park) ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony H. Tribull

(a) RESIDENCE NO. 1244 Spring (Morrell Park) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Tribull

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Ritired 3 yrs.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Tribull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Marian (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charlotte Tribull

(Address) 1244 Spring St. Morrell Park

15 Filed AUG 27 1921 ROBERT E. KRAUTER Registrar

BUREAU PERMIT CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1921, to Aug 25, 1921, that I last saw him alive on Aug 25, 1921, and that death occurred, on the date stated above, at 8 40 a. m.

The CAUSE OF DEATH* was as follows:

Acute dilation

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Abscess of Kidney

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hyndman M. D.

1/26/22 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 29 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Flat St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

~~Cause that got Lustacy~~

Not J. B non was it due to accident. Cause Unknown

Spec.—1-10-21—M&T—1500 Bks.

Emmel.

D 56452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56452

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Chesnut Hill Ave ST., Blair Rd. WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Emmel

(a) RESIDENCE NO. 2 Chesnut Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Emmel

6 DATE OF BIRTH (month, day, and year) Aug. 19. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Emmel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs William Bochum (Address) 2 Chesnut Hill Ave

15 Filed AUG 27 1921 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1921, to Aug 26, 1921, that I last saw him alive on Aug 26, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? at place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert J. Bebster, M. D.

, 19 (Address) 703 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 29 1921
20 UNDERTAKER H. Sander & Sons	ADDRESS 1710 Read St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PENCIL SHOULD NOT BE USED. ALL ITEMS should be stated EXACTLY. PHYSICIAN'S AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. AGE should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 ✓ D 56453

REGISTERED NO.

D 56453

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1733 Mc Culloh ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Witt

(a) RESIDENCE. NO. 1733 Mc Culloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married.

5a If married, widowed, or divorced (or) WIFE of Robert Witt

6 DATE OF BIRTH (month, day, and year) Exact, unknown, about 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Household duties

(b) General nature of Industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co Va Live in Balt- 38 years

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant William H. Witt (son) (Address) 1733 Mc Culloh St

15 Filed AUG 27 1921 19 ..... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/20, 1921, to 8/25, 1921, that I last saw h.. alive on 8/25, 1921, and that death occurred, on the date stated above, at 4.40 A.m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetis Coma

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis + Clinical

(Signed) R. H. Young M. D.

, 19 (Address) 1716 Jefferson,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt-Auburn Cemetery

DATE OF BURIAL Aug 29 1921

20 UNDERTAKER Wm R A Elliott

ADDRESS 1725- Ashland Av

N. B.—WRITE PLAINLY, with ink. All items should be stated. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. BIRTHPLACE: Information should be carefully supplied

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56454

CERTIFICATE OF DEATH.

119 D 56454

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 523 Exeter (St.) 3 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Smith

(a) RESIDENCE. NO. 523 Exeter St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 7 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed.

5a If married, widowed, or divorced (or) WIFE of James Smith.

6 DATE OF BIRTH (month, day, and year) Dec 25, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va. Lived in Balt - 30 years

PARENTS

10 NAME OF FATHER Harry Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Stones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant Mary A. Smith (Sister) (Address) 523 Exeter St

15 Filed AUG 27 1921 19 ROBERT I. GRAITH Registrar

Burial Permit Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24 1921

17

I HEREBY CERTIFY, That I attended deceased from 8/21, 1921, to 8/24, 1921, that I last saw h[illegible] alive on 8/24, 1921, and that death occurred, on the date stated above, at 6.06 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis. with complete retention

over

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis + Physical

(Signed) R. A. Gosling, M. D.

19 (Address) 1416 Jefferson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 28 1921
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56455

CERTIFICATE OF DEATH.

40 D 56455

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 Harr ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Walker

(a) RESIDENCE NO. 635 Harr ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 37

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER Isaac Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent-Island Md

12 MAIDEN NAME OF MOTHER Julia Ring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent-Island Md

14 Informant G mother Julia Johnson

(Address) 635 Harr St

15 ROBERT J. KRAUTER

Filed AUG 27 1921 19 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25. 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1921, to August 25. 1921; that I last saw her alive on August 24. 1921 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Brights Disease

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Brights Disease & Tumor of Stomach (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D. G. Kennard, M. D.

8-26 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 27, 1921
20 UNDERTAKER	ADDRESS
Wm R A Elliott	Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS... mation should be carefully supplied. AGE should be... CAUSE OF DEATH in plain terms, so that it may be pr... TION is very important. See instructions on back of ce... be stated EXACTLY. PHYSICIANS ... be properly classified. Exact statement of OCCUPA... of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malignant Tumor of Stomach.

Spec. 6-9-19—H. P. Co.—1000 Blks.

56456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

76D 56456

REGISTERED NO.....

1-PLACE OF DEATH Balto. Eye, Ear, & Throat Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 625 W. Franklin ST.: 20 WARD)

2-FULL NAME Raymond A. Myers

(a) RESIDENCE. No. 456 Furrow St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28-1900

7 AGE	Years	Months,	Days,	If LESS than 1 day, ...hrs. or ....min.
	21	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Work

(b) General nature of industry, business, or establishment in which employed (or employer) Mary Carey Training School

(c) Name of employer Md. Training School Balto. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER David Myers -

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Shipley

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Joseph C. Myers — (Address) 456 Furrow St.

15 Filed AUG 27 1921 ROBERT A. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24- 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to Aug. 24—, 1921—

that I last saw him alive on Aug. 23-, 1921,

and that death occurred, on the date stated above, at -3.45 P. m.

The CAUSE OF DEATH* was as follows:

Purulent Labyrinthitis

-Cerebral abscess (?) -

(duration) doubtful - yrs. mos. ds.

CONTRIBUTORY: (Secondary) Chronic Suppurative Otitis Media (duration) Since childhood - yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of July 27-1921

Was there an autopsy? Aug. 23-1921

What test confirmed diagnosis? Clinical & Surgical

(Signed) James Downey Jr., M. D.

, 19 (Address) - 579 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ridge Cemetery DATE OF BURIAL: Aug 27 1921

20 UNDERTAKER: F. B. Hupfeld ADDRESS 2236 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHRASES OF OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. Exact statement of AGE should be carefully supplied

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56457

D 56457

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH 1411 Arsquith St

CITY OF BALTIMORE: (No. 1411 Arsquith ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Sebsana Worick

(a) RESIDENCE. NO. 1411 Arsquith. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word): Widowed.

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of: Henry Worick

6 DATE OF BIRTH (month, day, and year): Feb 14, 1844

7 AGE — Years: 77 Months: 6 Days: 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Port Deposit Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Port Deposit (?)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Henry Lockwood (Address): 403 N Woodyear

15 Filed AUG 27 1921 19 [illegible] Registrar [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 24, 1921, that I last saw her alive on Aug 24, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. One mos. ds.

CONTRIBUTORY (Secondary): Cerebro Sclerosis (duration) One yr. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical

(Signed) A Woodyear M. D.

26, 1921 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: 8/27/21

20 UNDERTAKER: Geo J Puth ADDRESS 1725 Harford Av

N. B.—WRITE PLAINLY. WITH UNFADING INK. PHYSICIAN'S OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

Spec. 6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56458

56458

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1726 N. Mount ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Edw. Woods

(a) RESIDENCE. NO. 1726 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth B. Woods

6 DATE OF BIRTH (month, day, and year) 1-20-1880

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher 013
(b) General nature of industry, business, or establishment in which employed (or employer) Pork Packers
(c) Name of employer Jones & Lamb. Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Elizabeth B. Woods
(Address) 1726 N. Mount St.

15 Filed AUG 27 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25- 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20 . 1921 . to Aug. 25 . 1921 .
that I last saw h alive on Aug. 25 . 1921 .
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secundary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) George C. Page, M. D.
. 19 (Address) 1726 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 28 1921

20 UNDERTAKER Edward Ringgold ADDRESS 1463 7 Cam

N. B.—WHITE PLAINLY. WITH [illegible]
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S [illegible]
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56459

D 56459

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Balto, Md. ST., 24 X 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell Brahdt

(a) RESIDENCE NO. US. Public Health Hosp. #56 Baltimore WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs Mary E Brandt

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ----

031

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER UNKNOWN

13 BIRTHPLACE OF MOTHER (city or town) (State or country) UNKNOWN

14 Informant Edgar T Rosenbrock Registrar
(Address) US PHS Hosp. #56 Ft McHenry Md.

15 Filed AUG 27 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1921 to Aug. 23, 1921 that I last saw him alive on Aug. 23, 1921 and that death occurred, on the date stated above, at 6'15 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far adv. active.

8/13/21 (duration) --- yrs. --- mon ds.

CONTRIBUTORY (Secondary)
---- (duration) -- yrs. -- mos. -- ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Clinic report

(Signed) Thomas R. Payne M. D.
Senior Surgeon (R)

8/24 1921 (Address) US PHS Hosp. #56.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 27 1921

20 UNDERTAKER Sol Levinson — ADDRESS 1127 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful to see that all information should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56460

CERTIFICATE OF DEATH.

15 D 56460

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hospital (St.:) 10 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Watkins

(a) RESIDENCE. No. 821 Sterling St St.. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			13	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Gertrude Baskerville

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) John Hopkins Hospital Records

15 Filed AUG 27 1921 19 Robert A. Lotus Registrar
Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 10 . 1921, to Aug 23 . 1921, that I last saw h.. alive on Aug 23 . 1921, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Birth Injury

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) W. Brown, M. D.

19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL AUG 2 1921 19

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH INK. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56461

74 D 56461

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Young

(a) RESIDENCE. NO. 737 N. Gay St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct 11 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Joseph Tall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore Maryland

12 MAIDEN NAME OF MOTHER Mary Solomon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed AUG 27 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26 1921

17 I HEREBY CERTIFY, That I attended deceased from August 26, 1921, to August 26, 1921, that I last saw her alive on August 26, 1921, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation Shock

1 hour (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of August 26-1921

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. E. Broadrup. M. D.

8/26/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug 29 1921
20 UNDERTAKER Williams Cook	ADDRESS 502 E Nath.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56462 D 56462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

REGISTERED NO. 6

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 152 N. Lakewood ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Kahn

(a) RESIDENCE. NO. 152 N. Lakewood ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Kahn

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Self 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ralph Kahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Weeks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Children
(Address)

15 [illegible] 19 Robert P. Harrison, Registrar
[illegible] Burial Permit Clerk.]

AUG 28 1927

AUG 28 1927

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from July, 1924, to Aug 27, 1927.

that I last saw him alive on Aug. 27, 1927.

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows: Thrombo-Angiitis Obliterans

(See St. Agnes Hospital records etc.)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Amputation Leg

Did an operation precede death? Yes Date of before death St. Agnes Hospital

Was there an autopsy? Yes See records there

What test confirmed diagnosis? Clinical

(Signed) Harry Linder, M. D.

8/27, 1927 (Address) 141 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	8/28 1927
20 UNDERTAKER	ADDRESS
Jack Levis	1411 E. Baltimore St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Raynaud's Disease

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56463 D 56463

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST.: 18 WARD)

2-FULL NAME Miss Bella Anshel

(a) RESIDENCE. NO. 916 W. Lexington St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Typist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ely Anshel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fanny Chilpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis 1411 E. Baltimore

15 AUG 28 1921 Filed Robert P. Harrison, Registrar

AUG 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1921, to 8/27, 1921, that I last saw her alive on 8/27, 1921, and that death occurred, on the date stated above, at 6.25 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pyemia (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ernest Edelstein, M. D.

8/27, 1921 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Hebrew Cem	8/28 1921
20 UNDERTAKER Jack Lewis 1411 E Balto	ADDRESS

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK—Date of death should be stated EXACTLY. PHYSICIANS should be careful to see that it may be properly classified. Exact statement of OCCUPATION should be made. AGE should be carefully supplied. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56464

D 56464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 S Madeira ST.: 1 WARD)

2-FULL NAME Marie Hitchens

(a) RESIDENCE. No. 406 S Madeira ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. Hitchens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Kurlenska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Geo Hitchens 406 S Madeira St

15 Filed Aug 28 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27. 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1921, to Aug 27, 1921, that I last saw her alive on Aug 27, 1921, and that death occurred, on the date stated above, at 3.20 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilson D. Rogers M. D.

Aug 28 19 21 (Address) 801 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Aug 28 1921
20 UNDERTAKER	ADDRESS
Steven Kulakowski	[illegible]

AUG 28 1921

AUG 27 1921

LWRITE PLAINLY; with pen and ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Griggs)

Spmc.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56465

D 56465

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 Hanbert ST. 24 WARD)

2-FULL NAME. Melvin J. Griggs

(a) RESIDENCE. NO. 1431 Hanbert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8. 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Samuel H. Griggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Agnes Jackelska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Samuel H. Griggs. 1431 Hanbert St.

15 Filed AUG 28 1921 19 Robert P. Harrison, Registrar

AUG 28 1921 Burial Permit Clerk.

AUG 27 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 . 1921 . to August 27 . 1921 . that I last saw h— alive on August 26 . 1921 . and that death occurred, on the date stated above, at 3:20 A. m.

The CAUSE OF DEATH* was as follows:

Summer Diarrhea 3 days.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Apsom.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) E. L. Kerr M. D.

8-27. 1921 (Address) 827 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus, Cem.	Aug 28 1921
20 UNDERTAKER W. J. Sadowski,	ADDRESS 905 S Ann

I. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 56466

D 56466

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 Lanvale (Laurens) ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Ann Hamilton

(a) RESIDENCE. NO. 618 Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Taylor Hamilton

6 DATE OF BIRTH (month, day, and year) Sept 10 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Bulla, Co
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Taylor Hamilton
(Address) 618 Lanvale St

Filed AUG 26 1921 Robert P. Harrison, Registrar

AUG 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1921, to Aug 25, 1921, that I last saw h[illegible] alive on Aug 25, 1921, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Organic Heart Disease (Myocarditis)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Brown, M. D.

8/26 1921 (Address) 1837 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 29th 1921
20 UNDERTAKER Geo. Weber & Son	ADDRESS 2503 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of OCCUPATION should be properly classified. AGE should be carefully supplied

(Debour)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56467

D 56467

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.:) 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Debaun.

(a) RESIDENCE. No. 707 Ellwood Ave (St.:) (Ward.)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 13-1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	8	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady. 67

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) City.

PARENTS

10 NAME OF FATHER Nicholas Debour.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) City.

12 MAIDEN NAME OF MOTHER Johanna Seibert.

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) City.

14 Informant Nicholas Debour.
(Address) 707 E. Ellwood Ave.

15 Robert P. Harrison,
19 Registrar

AUG 28 1921
AUG 27 1921
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1921, to Aug 26, 1921, that I last saw h.. alive on Aug 26, 1921 and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Over

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cellulitis Throat.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 25, 21

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) S. W. Kinney, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Aug. 29 1921

20 UNDERTAKER Lilly & Zeiler.

ADDRESS 403 S. Wolfe St.

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PUBLIC RECORD. PHYSICIANS should state stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPA- mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56468 ✓ 138 D 56468

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard + Green (ST.) 13 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lillian Gertrude Fisher

(a) RESIDENCE. NO. 3834 Hickory Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Franklin Fisher

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Lawrence Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Bula Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Walter F Fisher (Husband)

(Address) 3834 Hickory Ave.

15 Filed AUG 28 1921 Robert P. Harrison, Registrar

AUG 28 1921

AUG 27 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26 1921

17 I HEREBY CERTIFY, That I attended deceased from August 26, 1921, to August 26, 1921, that I last saw her alive on August 26, 1921, and that death occurred, on the date stated above, at 11 05 P m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. 2 mos. 2 hrs.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of August 26-1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Morris Reese, M. D.

8 26 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's R DATE OF BURIAL Aug 27 1921

20 UNDERTAKER A S Marshall ADDRESS 353 Hollins St

NOTICE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Puerperal

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56469 D 56469

CERTIFICATE OF DEATH.

1920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 141 Prospect Av ST.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Gansenberg

(Residence in Baltimore: No. 141 Prospect Ave St., Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct 2, 1852
(Month) (Day) (Year)

7-AGE, 68 yrs. 10 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, George Oliver

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary E Cunningham

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Gansenberg

(Address) 141 Prospect Ave

15- AUG 28 1921 Filed, 191.. Robert P. Harrison, Registrar.

AUG 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 27, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1921, to Aug 27 1921, that I saw h[illegible] alive on Aug 27 1921, and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 2 ds.

(Signed) W D Love M. D.

Aug 28, 1921 (Address) 836 W. Mont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel — DATE OF BURIAL, Aug 30 1921

20-UNDERTAKER J S Marshall — ADDRESS 3509 Eastern Av

WRITE PLAINLY.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

(Briscoe)

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56470

D 56470

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 955 Druid Hill Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. Briscoe

(Residence in Baltimore: No. 955 Druid Hill Ave St.; 60 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1843 (Year)

7-AGE, 78 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or Country), Prince George Co. Md.

PARENTS.

10-NAME OF FATHER, Edward Berry

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie M. Stall

(Address) 955 Druid Hill Ave

15- Robert F. Harrison, ..., 191.....

Registrar.

Burial Permit Clerk.

AUG 25 1921

AUG 27 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 25, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 20 1921, to August 25 1921, that I saw her alive on August 24 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows: Chronic Gastritis

(Duration) 4 yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) ..... yrs. 5 mos. ..... ds.

(Signed) Chas. E. Simmons M. D.

August 27, 1921 (Address) 712 S. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Aug. 28, 1921

20-UNDERTAKER Samuel Kennedy ADDRESS 378 Wash

WRITE PLAINLY, WITH UNFADING INK.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 56471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56471

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 4710 Greenmount ST.: 27 WARD)

2-FULL NAME William G. Heffner

(Residence in Baltimore: No. 4710 Greenmount St.: yrs., 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 30 (Day), 1873 (Year)

7-AGE, 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: At Home (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jacob Stock

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary A. Stock

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry C. Heffner

(Address) 4710 Greenmount

15- AUG 28 1921 Robert P. Harrison,

191 Registrar.

AUG 27 1921, Burial Permit Clerk.

AUG 28 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park

DATE OF BURIAL, Aug 29 1921

20-UNDERTAKER William Cook

ADDRESS 501 E North Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Ad Imbay 2938 E. Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56472 — 104 — D 56472

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 1002 East Biddle St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Veron D Hopkins

(Residence in Baltimore: No. 1002 East Biddle St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 23, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimor Md

PARENTS.

10-NAME OF FATHER, David C Hopkins

11-BIRTHPLACE OF FATHER (State or Country) Baltimor Md

12-MAIDEN NAME OF MOTHER Minnie L. Waltemeyer

13-BIRTHPLACE OF MOTHER (State or Country). Baltimor Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David C Hopkins

(Address) 1002 E. Biddle

15- AUG 28 1921 Robert P. Harrison,
AUG 28 1921, 191.....
Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus

(Duration) ...yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs....mos....ds.

(Signed) ..... M. D.
(Coroner.)

Aug 27, 1921 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Aug 29, 1921

20-UNDERTAKER William Cook — ADDRESS 502 E Nor

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.56473 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.56473

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Clara Boland

(a) RESIDENCE. NO. 310 E. 25th St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Boland

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not any.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER. Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant (Address) John Boland 310 E. 25th St.

15 Filed AUG 29 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-28 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-17, 1921, to 8-28, 1921.

that I last saw h[er] alive on 8-28, 1921.

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

chr. nephritis

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) apoplexy. Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? chemical

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Co. DATE OF BURIAL 8/30 1921

20 UNDERTAKER Margaret D. Flynn ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56474 D 56474

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 44 Poultney ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura V. Wills

(Residence in Baltimore: No. 44 Poultney St.; 74 yrs., 11 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH, Dec 29, 1846 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
74 yrs. 11 mos. 28 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John D. Lancasty

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Martha Prnell

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L Bishop

(Address) 44 E Poultney

15- AUG 28 1921 Robert F. Harrison, (Filed, 191.) Burial Permit Clerk Registrar.

AUG 28 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 27, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10th 1921, to Aug 27 1921, that I saw her alive on Aug 27 1921, and that death occurred, on the date stated above, at 2.45 p m.

The CAUSE OF DEATH* was as follows: Cancer of Rectum

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. J. Smith M. D.

Aug 27, 1921 (Address) 118 N Calhoun St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Pk Cem	8/29, 1921.
20-UNDERTAKER	ADDRESS
J. Fus Mitchell	130 S. Fort

WRITE PLAINLY, WITH CONTRIBUTORY CAUSE OF DEATH. PHYSICIANS NAME AND ADDRESS should be stated EXACTLY. AGE should be carefully supplied. Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Blks.

(Printz)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56475

92

D 56475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH W. 5 Lane 8

CITY OF BALTIMORE: (No. Biddle St Ext & Bonney St.; WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Printz

(Residence in Baltimore: No. Biddle St Ext & Bonney Lane St.; 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)~~ Widowed

6-DATE OF BIRTH, Dec 27, 1856 (Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): NO

9-BIRTHPLACE, (State or Country), Maine

PARENTS.

10-NAME OF FATHER, Theodore Randall

11-BIRTHPLACE OF FATHER (State or Country), Maine

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maine

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Newbert Randall

(Address) 1941 E 31st St

15-

Filed Aug 28, 1921 Robert P. Harrison, Registrar.

~~Burial Permit Clerk.~~

AUG 28 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 26, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1921, to Aug 26 1921, that I saw her alive on Aug 26 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. E. Lane M. D.

Aug 27 1921 (Address) 1301 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Aug 29th 1921

20-UNDERTAKER Leo. G. Cook

ADDRESS North Harford Ave

WRITE PLAINLY, WITH UNFADING INK.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~D 56476~~ 6

CERTIFICATE OF DEATH.

105 D 56476

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 Upton ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Logan

(Residence in Baltimore: No. 1308 Upton St.; ....yrs,,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... June (Month) 25 (Day), 1918 (Year)

7-AGE,	If LESS than 1 day,
3 yrs. 2 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... Hm

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry Logan

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elsie Fleming

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsie Fleming

(Address) 1308 Upton

15 AUG 29 1921 ROBERT P. KRAUSE Chief Clerk

Filed....., 191... Bureau of Vital Statistics Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1921, to Aug 26 1921, that I saw h.r alive on Aug 26 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration)....yrs....mos....ds.

(Signed) Wm E. Burton M. D.

Aug 27, 1921 (Address) 912 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Zion Bur	Aug 29 1921
20-UNDERTAKER Daniel Easton	ADDRESS 916 Ea ave

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Hunter

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 175 D 56477

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 110 Prot. Hospl ST.; 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jasper Price Hunter

(Residence in Baltimore: No. 824 Ashland Ave St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mar

6-DATE OF BIRTH, Sept 26, 1918
(Month) (Day) (Year)

7-AGE, 3 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country). Loveland S C
Live in Balt- 6 month

PARENTS.

10-NAME OF FATHER. Jasper S Hunter

11-BIRTHPLACE OF FATHER (State or Country) Live in Balt- 6 month Loveland S C

12-MAIDEN NAME OF MOTHER not Princess Pearl Merriman

13-BIRTHPLACE OF MOTHER (State or Country). Loveland S C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father Jasper S Hunter

(Address) 824 Ashland Ave

15- AUG 29 1921 BOARD OF HEALTH

Filed ....., 191.... Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Traumatic fracture by auto

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W Kirk Faulkner M. D.
(Coroner.)

Aug 27, 1921 (Address) 9 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence South Carolina

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Aug 28, 1921.

20-UNDERTAKER Mrs R A Elliott

ADDRESS 725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 56478

D 56478

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 511. S. Green ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Grimes

(a) RESIDENCE. NO. 511 S. Green St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13- 1877-

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry Armstrong & Co — Balto. Md.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Nelson Brown

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Dickson.

13 BIRTHPLACE OF MOTHER (city or town) Balto — (State or country)

14 Informant Lilly Harris.

(Address) 511 S Green

15 Filed AUG 29 1921 19 Daniel Farrell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug - 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1921, to Aug 26, 1921, that I last saw h.r alive on Aug 20, 1921, and that death occurred, on the date stated above, at 5.55 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Breast.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) metastases mediastinum

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes. Date of Feb. 24-1921

Was there an autopsy? no

What test confirmed diagnosis? Pathological exam of tumor.

(Signed) C. Hunt, M. D.

8-27 1921 (Address) 331 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Aug 29 1921
20 UNDERTAKER	ADDRESS
Sam'l W. Chase & Son	1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56479

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56479

CERTIFICATE OF DEATH.

29

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. New City Hospital, Bay View DIST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wenceslau Chalupa

(a) RESIDENCE. No. 702 N. Belnord Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Chalupa

6 DATE OF BIRTH (month, day, and year) Sept 7, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital records
(Address) New City Hospital

15 Filed AUG 29 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27 1927

17 I HEREBY CERTIFY, That I attended deceased from July 16 1921 to August 27 1921, that I last saw him alive on August 26th 1921, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. E. Bradrup. M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakhill	Aug 29 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

530 56480

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 706 W. Barre St. (ST.) 22 (WARD)

2-FULL NAME Sadie Agro,

(a) RESIDENCE. No 706 W. Barre St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Agro.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Mrs. Sadie Agro. 220 N Barre St.

15 Filed AUG 29 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1921, to Aug. 27, 1921, that I last saw her alive on Aug. 26, 1921, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Differential Blood Count

(Signed) E. L. Pearson, M. D.

Aug. 28, 1921 (Address) 2314 E. Balt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: Aug 29 1921

20 UNDERTAKER: J J Fa[illegible]

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

56481

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D 56481

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Bedford

(a) RESIDENCE. No. None ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records.

(Address): New City Hospital.

15 Filed AUG 29 1921 ERNEST I KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26 1921

17 I HEREBY CERTIFY, That I attended deceased from January 13 1917. to August 26. 1921.

that I last saw her alive on August 25. 1921.

and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Paralysis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Brandage. M. D.

8/27/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Aug 29 1921
20 UNDERTAKER	ADDRESS
Mrs J. G. Locke	1302 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56482

40 D 56482

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Little Sisters of the Poor

CITY OF BALTIMORE: (No. Preston & Valley Sts. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Warren

(a) RESIDENCE. NO. Little Sisters of Poor. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawrence J. Warren

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	abt. 72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Elias Terry

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Elizabeth Fairbanks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Sister Florence. (Address) Preston & Valley.

15 Filed AUG 29 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1921

17 I HEREBY CERTIFY, That I attended deceased from [illegible] 19 . to 19 .

that I last saw h alive on Aug 21 . 1921.

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Oesophagus —

About 12 mos (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner. M. D.

Aug 27. 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug 30 1921
20 UNDERTAKER	ADDRESS
Josiah Pyfer.	1600 N. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56483

CERTIFICATE OF DEATH.

79 D 56483

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 W. Saratoga St.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Coleman

(a) RESIDENCE. No. 1029 W. Saratoga St.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Coleman Gardenier

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Thomas Reigold
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Susan Reigold
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant George Mulgrew (Address) 1029 W. Saratoga St

15 Filed AUG 29 1921 19 ROBERT I KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1921, to Aug 26, 1921, that I last saw h[illegible] alive on Aug 26, 1921, and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Exhaustion ?
Rheumatism (duration) 6? mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Hughes M. D.
Aug 27, 1921 (Address) 1473 D.I. Fillmore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 30 1921

20 UNDERTAKER James A. Quinn ADDRESS 385 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be made. CAUSE OF DEATH in plain terms, so that it may be understood by a clerk of certificates. See instructions on back of certificates. This information is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56484

D 56484

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 718 McCulloh ST.: 14 WARD)

2-FULL NAME Nannie May Blackwell

(a) RESIDENCE. NO. 1718 McCulloh ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-17-1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Garment Presser #6

(b) General nature of industry, business, or establishment in which employed (or employer) Underclothing Mfg.

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Lancaster Co.
(State or country) Va.

PARENTS

10 NAME OF FATHER Chas. Blackwell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Northumberland Co. Va.

12 MAIDEN NAME OF MOTHER Betty A. Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Essex Co. Va.

14 Informant Betty A. Johnson
(Address) 1718 McCulloh St

15 Filed AUG 29 1921 ROBERT F. KRUGER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-26- 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-24, 1921, to 8-26, 1924, that I last saw her alive on August 26, 1924, and that death occurred, on the date stated above, at 4:10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George C. Page, M. D.

, 19 (Address) 1720 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 30 1921
20 UNDERTAKER James H. Lemmon	ADDRESS 1313 Pratt St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PAY... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56485

56485

CERTIFICATE OF DEATH.

14 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Eutaw Place ST.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Russell

(a) RESIDENCE. NO. 1613 Eutaw Place ST.. WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? 70 yrs. 6 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Alexander H. Russell

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER C. W. Keech

11 BIRTHPLACE OF FATHER (city or town) Providence (State or country) Rhode Island

12 MAIDEN NAME OF MOTHER Rachel S. Hughes

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant George H. Cox (Address) 1007 Cathedral St.

15 Filed AUG 29 1921, 19 ... Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to August 27, 1921, that I last saw h-- alive on August 27, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Hypertension
Chr. Interstitial Nephritis
(duration) 10+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema.
(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) George H. Cox, M. D.

, 19 (Address) 1007 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Aug 29 1921

ADDRESS

20 UNDERTAKER: STEWART & [illegible] COMPANY (WILLIAM P. [illegible])

[illegible] NORTH AVE.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56486

CERTIFICATE OF DEATH.

1320 D 56486

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 306 S. Poppleton ST.; 18 WARD)

2-FULL NAME Mrs Mary Dorsenbaugh

(a) RESIDENCE. NO. 306 S. Poppleton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Michael Dorsenbaugh

6 DATE OF BIRTH (month, day, and year) Unknown 1853.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thos Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Crouch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Jos Dorsenbaugh
(Address) 306 S Poppleton St

15 Filed AUG 29 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 7/21/ 1921, to 8/26/ 1921.

that I last saw h... alive on 7/26/21, 19...

and that death occurred, on the date stated above, at 7.0 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J Levy, M. D.

8/27, 1921 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Aug 30th 1921
20 UNDERTAKER	ADDRESS
J. J. Cowan & Son	901 Holland St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56487

CERTIFICATE OF DEATH.

X 9 1 D 56487

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Balto, Md. 23 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Hooker

(a) RESIDENCE NO. US. Public Health Hosp. #56 ST. Baltimore WARD Md.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Doctor.

(b) General nature of industry, business, or establishment in which employed (or employer): ---

(c) Name of employer: ---

9 BIRTHPLACE (city or town) (State or country): Texas.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Edgar T Rosenbrock Registrar
(Address): US. PHS Hosp. #56 Ft. McHenry

15 Filed AUG 29 1921 . 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26, 19 21

17 I HEREBY CERTIFY, That I attended deceased from Aug. 26, 19 21 to Aug, 26. 19 21.

that I last saw him alive on Aug. 26, 19 21

and that death occurred, on the date stated above, at 6'15 P.m.

The CAUSE OF DEATH* was as follows:
Pneumonia broncho.

Aug. 26,/21 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ---- -- (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas R. Payne M. D.

, 19 (Address) Senior Surgeon (R) USPHS Hosp. #56 Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemtry

DATE OF BURIAL: Aug 29 19 21

20 UNDERTAKER: Sol Grunson

ADDRESS 427 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56488 ✓ D 56488

CERTIFICATE OF DEATH.

X 120

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Balto ST., WARD)

REGISTERED NO. N

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Dallenger

(a) RESIDENCE NO. US. Public Health Hosp. ST. #56 Balto, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: tin smith

(b) General nature of industry, business, or establishment in which employed (or employer): ----

(c) Name of employer: ---

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Edgar T Rosenbrock Registrar US. PHS Hosp. #56 Balto, Md.

15 Filed AUG 29 1921 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26/21

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1921 to August 26 1921.

that I last saw him alive on August 26, 1921,

and that death occurred, on the date stated above, at 10'55 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis Chr. Nephritis Chr. interstitial. Otitis media Chr.

Cholecystitis acute. suppurative

June 8, /21 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure)

--- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Aug.26/21

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas B. Payne M. D.

8/26/21 (Address) US PHS Hosp. #56 Balto, Md. Senior Surgeon (R)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemet

DATE OF BURIAL Aug 27, 21

20 UNDERTAKER Sol Levinson

ADDRESS E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56489

CERTIFICATE OF DEATH.

4 1 / 5042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 Linden ave ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Martha Hyman

(a) RESIDENCE. NO. 2509 Linden ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. — mos. — ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Toatman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob Hyman (Address) 2509 Linden Ave

15 Filed AUG 29 1921 ROBERT P. CHESTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1921, to Aug 28, 1921, that I last saw her alive on Aug 28, 1921, and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lower Intestines with Metastasis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nathan J Davidow, M. D.

, 19 (Address) 30 S. O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Blair Rd	Aug 29 1921
20 UNDERTAKER	ADDRESS
Sol Levinson	1127 E. Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56490

CERTIFICATE OF DEATH.

42

56490

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belmont & Eleanor ave ST., 15 WARD)

2-FULL NAME Minnie J Merryman

(a) RESIDENCE NO. Belmont Apartments ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 9 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of C. S. Merryman

6 DATE OF BIRTH (month, day, and year) Feb 14 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	58	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) md

PARENTS

10 NAME OF FATHER John Fishack

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) md

12 MAIDEN NAME OF MOTHER Amanda Homer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) md.

14 Informant (Address) Mrs Charles A. Gladding Baltimore city

15 Filed AUG 30 1921, 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1921, to Aug 27, 1921, that I last saw h alive on Aug 27, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) a yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinomatosis

(duration) yrs. a mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of March 21

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) T. M. Lindsay M. D.

Aug 28, 1921 (Address) 826 N Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park cemetery — DATE OF BURIAL: aug 29 1921

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 56491

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 56491

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1129 Clarkson St. ST.: 23 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry A. Shreet.

(Residence in Baltimore: No. 1129 Clarkson St. St.: 20 yrs., ---- mos. ---- ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower.

6-DATE OF BIRTH, August 29th. 1852., 1
(Month) (Day) (Year)

7-AGE, 68 yrs. 11 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Upholsterer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Frederick Shreet.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leon C. Shreet. (son)

(Address) 24 E. Hamburg St.

15- AUG 29 1921 ROBERT J. TRAUTER

Filed....., 191.... REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 26th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Otto K. Eisenhardt M. D.
(Coroner.)

Aug. 27, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Aug 30, 1921

20-UNDERTAKER Wm Cook — ADDRESS 1012 Madison Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56492

CERTIFICATE OF DEATH.

2479

D 56492

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1606 Webster St. ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Ziegler. 70 ---------

(Residence in Baltimore: No. 1606 Webster St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH, ... Do not know. ....., 1 .....
(Month) (Day) (Year)

7-AGE, ... 70 ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Joseph Ziegler.

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania.

12-MAIDEN NAME OF MOTHER Jane Waterworth.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Ziegler. (brother)

(Address) 919 Homestead St.

15- AUG 29 1921 ROBERT J. KRAUTER
Filed ....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 26th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto H. Finkbeiner M. D.
(Coroner)

Aug. 27., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet.	Aug 29, 1921
20-UNDERTAKER Jm Cook	ADDRESS 501 Park Ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 56493

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56493

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3815 Lloyd Av ST.: 28 WARD)

2-FULL NAME Peter R. Krueger

(a) RESIDENCE. NO. 3815 Lloyd Av ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	3	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Alexander Krueger
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany
12 MAIDEN NAME OF MOTHER Amelia Garneina
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Emily M Krueger
(Address) 3815 Lloyd St

15 Filed [illegible] 19 ROBERT J. CRAWFORD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Aug 27 1921, that I last saw him alive on Aug 26 1921, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
Absent 2 yrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical

(Signed) W. S. Abbott, M. D.

Aug 27/21 (Address) 2220 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Aug 30 1921

20 UNDERTAKER Mather Fahey & Sons ADDRESS 827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56494

CERTIFICATE OF DEATH.

56494

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Dorsey

(a) RESIDENCE. No. 1829 Harford St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44 (?) (Exact)	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Joseph H. Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Sarah Joyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records, (Address) New City Hospital.

15 Date AUG 29 1921 [illegible] Registrar

Burial permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25 1921

17 I HEREBY CERTIFY, That I attended deceased from August 24, 1921, to August 26, 1921, that I last saw h im alive on August 25, 1921, and that death occurred, on the date stated above, at 9:25 A. m.

The CAUSE OF DEATH* was as follows:

Rheumatic pancarditis

(duration) 20? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Mitchell, M. D.

8/27/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	8/30 1921
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	18 W. Mt Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56495

CERTIFICATE OF DEATH.

D 56495

REGISTERED NO. 14792

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Union Memorial Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Kimberly Jr.

(a) RESIDENCE. NO. Catonsville Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15 years	one	four	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER George Kimberly

11 BIRTHPLACE OF FATHER (city or town) D. C.
(State or country)

12 MAIDEN NAME OF MOTHER Alice Roberts

13 BIRTHPLACE OF MOTHER (city or town) Nashville
(State or country) Tennessee

14 Informant George W. Kimberly Jr.
(Address) Catonsville Md.

15 Filed AUG 29 1921 BURIAL PERMIT ISSUED
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 8, 1921, to Aug 26, 1921, that I last saw him alive on Aug 26, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia, acute osteomyelitis, bronchial pneumonia, cholecystitis pericarditis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) pneumonia, two days

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Penn.

Did an operation precede death? yes Date of Aug 8 & 9, 21

Was there an autopsy? no.

What test confirmed diagnosis? Operation.

(Signed) George E. H. Hardy, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	8/29 1921
20 UNDERTAKER	ADDRESS
Chas. F. Evans & Son	1180 N. Mt.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-56496

149565

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56496 CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Savoy.

(a) RESIDENCE. NO. 1217 McCulloh St. ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married.

5a If married, widowed, or divorced (or) WIFE of Herbert Savoy (Husband) Same Address.

6 DATE OF BIRTH (month, day, and year) March 23 1897.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H-Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Edward Wyatt (dead)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Julia Burl.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Johns Hopkins Hospital Record

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19 . 1921 . to Aug 28. . 1921 . that I last saw her alive on Aug 28, . 1921 . and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Brain abscess.

Chronic mastoiditis.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of { 8-14-21 8-30-21 9-5-21

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) E. N. Brown. M. D.

. 19 (Address) Johns Hopkins.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Aug 29 1921
20 UNDERTAKER	ADDRESS
Jos. Henry Smith	313 Argyle Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56497

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56497

CERTIFICATE OF DEATH.

1920

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Geo Adams ST.: 15 WARD)

2-FULL NAME 1508 Mount ST.

(a) RESIDENCE. NO. 1508 Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. PHYSICIAN should state name and address of informant. AGE should be stated EXACTLY. PHYSICIAN should be careful to see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should state name and address of informant. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful to see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
~~Male~~ Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
53	-	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md

PARENTS

10 NAME OF FATHER Elijah Adams

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co (State or country) Md

14 Informant (Address) Sarah Adams 1508 Mount St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26 1921

17 I HEREBY CERTIFY, That I attended deceased from ~~April~~ 6/1, 1921, to 8/26, 1921, that I last saw him alive on 8/26, 1921, and that death occurred, on the date stated above, at 9 1/2 m.

The CAUSE OF DEATH* was as follows:

(a) Interstitial Aortic endocarditis

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 2134 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Aug 28 1921

20 UNDERTAKER Edw. Ringgold — ADDRESS 1463 W Lanvale

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial Nephritis

Wassermann negative.

Not tuberculous

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56498

CERTIFICATE OF DEATH.

D 56498

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 S. Robinson ST., 1 WARD)

2-FULL NAME Mary Kuntz

(a) RESIDENCE No. 15 S Robinson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emanuel Kuntz

6 DATE OF BIRTH (month, day, and year): Mar- 1844

7 AGE: Years 77; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Sistek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Lowtham

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Henry Kuntz (Address) 15 S Robinson St

15 Filed ..... 19 ..... LAWRENCE J. KRAUTER Registrar

Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-26 19 21

17 I HEREBY CERTIFY, That I attended deceased from 8-6, 19 21, to 8-26, 19 21

that I last saw h[illegible] alive on 8-26, 19 21

and that death occurred, on the date stated above, at 3.15 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Endocarditis

Apoplexy

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Surgeon

(Signed) J. T. Ryan M. D.

8-27-21 19 (Address) 400 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL 8-29 19 21

20 UNDERTAKER: J. A. Moran

ADDRESS 3 and E Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56499

56499

CERTIFICATE OF DEATH.

170

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2131 W North Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen J Mc Gee

(a) RESIDENCE. No. 2131 W North Ave ST., ... WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hswk 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Matthew McGee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thos McGee
(Address) 2131 NorthAve

15 Filed ..... , 19 ..... Registrar

AUG 29 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug 26, 1921, that I last saw her alive on Aug 26, 1921, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) Edwin Myers, M. D.

, 19 (Address) 1771 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	8/29/21 19

20 UNDERTAKER	ADDRESS
J J Fahey &Sons	1318LightSt

MARGIN RESERVED FOR BINDING—N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56500 ✓ 152 D 56500

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3602 C Leatrut Ave ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Schneider

(a) RESIDENCE. No. 3602 C Leatrut Ave WARD. 13

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 24-1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER John Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Mary P. Dyffenbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant John Schneider (Address) 3602 Leatrut

15 Filed AUG 29 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1921, to Aug. 27, 1921, that I last saw h... alive on Aug. 27, 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Defective nasal

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Streptococcus

(Signed) C. F. Knighton, M. D.

Aug 27, 1921 (Address) 320 Dorsey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Aug 29 1921

20 UNDERTAKER ADDRESS

Chenoweth & Son Chestnut

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS' FOUND BLANK mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56501

CERTIFICATE OF DEATH.

D 56501

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2829 Erdman Ave. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irvin Schrieve Pentz

(a) RESIDENCE. No. 2829 Erdman Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Luella Pentz

6 DATE OF BIRTH (month, day, and year) May 16.1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant(retired)

(b) General nature of industry, business, or establishment in which employed (or employer): Groceries

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: William Fletcher Pentz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Rebecca Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co. Maryland

14 Informant: Luella Pentz

(Address): 2829 Erdman Ave.

15 Filed AUG 29 1921 ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1921, to aug 27 1921.

that I last saw h... live on aug 27 1921.

and that death occurred, on the date stated above, at 8:00P m.

The CAUSE OF DEATH* was as follows:

Syphilis of Liver &
Pulmonary T.B. (duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary T.B. (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Wassaman Test

(Signed) J. H. Thomas M. D.

aug 29 1921 (Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 8-30-21 19

20 UNDERTAKER: H.E.Hughes — ADDRESS: 424 N.Broadway

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Every item must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56502

109

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (ST.:) 70 (WARD)

2-FULL NAME Mrs Sarah Michaelis

(a) RESIDENCE. No 1929 Mc Henry St. ST. 20th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Aug E. Michaelis

6 DATE OF BIRTH (month, day, and year) June 18-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	29 yrs.	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Burke.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alberta Lipsy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Aug E. Michaelis 1929 Mc Henry St

15 Filed AUG 29 1921, 19... ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-28-21, 19..., to 8-29, 1921.

that I last saw h[illegible] alive on 8-29-, 1921.

and that death occurred, on the date stated above, at 3:4 m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-29 21

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Sept 1 - 19 21

20 UNDERTAKER: F. B. Wappert — ADDRESS: 2236 Fred'k Ave

AUG 29 1921

MARGIN MUST BE KEPT CLEAR

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that on back of certificates. TION is very important. See instructions on back of certificates.

D 56503 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 172 D 56503

REGISTERED NO. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 216+218 W Pratt St. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pvt Army

(Residence in Baltimore: No. — St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, September 25, 1901
(Month) (Day) (Year)

7-AGE, 21 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farm

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Pat. Henry

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Martha Jones

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Henry

(Address) Sargent Md

15- AUG 29 1921 ROBERT J. KRAUTER, M. 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 25, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest and autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest and autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contusion of brain & laceration of brain & hemorrhage & compression of brain

Fallen Timber (Duration) yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Accidental

(Duration) yrs. mos. ds.

(Signed) W. T. Riley M. D.
(Coroner.)

Aug 29, 1921. (Address) 1057 Ruxton Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bentonville Cem Bentonville Va.

DATE OF BURIAL, Aug 30 1921

20-UNDERTAKER J. J. Cowan & Son

ADDRESS 701 Hollins St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56504 — 120 D 56504

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1705 Crystal Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. R. Amos

(a) RESIDENCE. NO. 1705 Crystal Ave ST.. WARD.

(Usual place of abode) abvd. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Amos

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abvd.	75	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired section fo

(b) General nature of industry, business, or establishment in which employed (or employer) St. Thomas Episcopal

(c) Name of employer Church 082

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Amos

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER Mary E. Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Mrs. Catherine Amos

(Address) 1705 Crystal Ave

15 AUG 29 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1920, to Aug 29, 1921, that I last saw him alive on August 27, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Edema

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine - symptoms.

(Signed) Daniel Fiegel, M. D.

, 19 (Address) 1506 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug. 31st 1921
20 UNDERTAKER Henry Hoch's Sons	ADDRESS 1301 E Eager

MARGIN RESERVED

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... should be stated EXACTLY. PHYSICIANS' ... mation should be carefully supplied. AGE should ... CAUSE OF DEATH in plain terms, so that it may ... may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56505

91

D 56505

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Nursery & Child's Hospital — REGISTERED NO.....

CITY OF BALTIMORE: (NO. Franklin & Schroder ST. 5 1 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Clothier

(a) RESIDENCE. NO. Nursery & Childs Hosp ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 6-1920

7 AGE — Years: 1 — Months: 7 — Days: 21 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chestertown, Md.

PARENTS

10 NAME OF FATHER Norman Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma May Clothier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chestertown Maryland

14 Informant

(Address) [redacted]

15 Filed AUG 29 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1921, to Aug. 28, 1921, that I last saw her alive on Aug. 28, 1921, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Heart Dilatation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Isaac J. Kreuzler M. D.

19 (Address) 706 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: AUG 31 1921

20 UNDERTAKER ..... ADDRESS .....

Commissioner Health.

AUG 29 1921

MARGIN—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

308

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56506 ✓ D 56506

91

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3303 Abell Ave ST., 12 WARD)

2-FULL NAME Edmund J. Mullaney

(a) RESIDENCE NO. 3303 Abell Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 7/19

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edmund Mullaney

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Florence Gosling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edmond J. Mullaney (Address) 3303 Abell Ave

15 Robert F. [illegible] Registrar

AUG 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1924, to Aug 28, 1924, that I last saw him alive on Aug 27, 1924 and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. E. Knipp, M. D.

8/27, 1924 (Address) H. E. Knipp 1002 Eutaw Savings Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 30 1924
20 UNDERTAKER	ADDRESS 1031
E Schumacher Son	Hanover

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56507

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1648 Pennsylvania Ave ST., 14 WARD)

REGISTERED NO. 1524

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Stevens

(a) RESIDENCE NO. 1648 Pennsylvania Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED—THIS IS A PERMANENT RECORD. Every line must be filled. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every line must be filled. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel E. Stevens

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	81.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent Co Md

PARENTS

10 NAME OF FATHER: Elizabeth Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Co Md

12 MAIDEN NAME OF MOTHER: Ann Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co Md

14 Informant (Address): Alex. Stevens 1648 Pennsylvania Ave

15 Filed Aug 25 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 25 1921 to Aug 27 1921.

that I last saw him alive on Aug 27 1921,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cardiac and respiratory asthenia.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Tobias Kemp M. D.

Aug 29, 1921 (Address) 1 S Kendall Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Park	Aug 29 1921
20 UNDERTAKER: H. Kirkwood Sons	ADDRESS: Baltimore

Spec.—6-9-19—H. P. Co.—1000 Blks.

14963 D 56508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 56508

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Smith.

(a) RESIDENCE. No. 134 S. Bethel St. City ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced HUSBAND of Emma Sadler (Aunt) 134 S. Bethel St. City

WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1902.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Potter.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital

15 Filed AUG 29 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1921, to Aug 27, 1921, that I last saw h[illegible] alive on Aug 27, 1921, and that death occurred, on the date stated above, at 6 35 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 3 mos. wks ds.

CONTRIBUTORY (Secondary) Syphilis, tertiary (congenital?) Gumma of testicle, ulcer (duration) 8 yrs. at least ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann, Blood urea, phthalein, urine exam.

(Signed) [illegible] M. D.

8-29, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 31 1921
20 UNDERTAKER	ADDRESS
Jas. H. Skinner	1625 E. Mad St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. AGE should be carefully supplied. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 56509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56509

REGISTERED NO.

1-PLACE OF DEATH New City Hospital

CITY OF BALTIMORE: (No. 82 ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Phillips

(a) RESIDENCE. No. 305 Nw St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record (Address) New City Hosp.

15 AUG 30 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13. 1921. to Aug. 27. 1921. that I last saw h alive on Aug. 27. 1921. and that death occurred, on the date stated above, at 6:15 P.m.

The CAUSE OF DEATH* was as follows: Cerebral thrombosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) Clyde Mitchell M. D.

8/29 1921 (Address) New City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Aug 30 19 21

20 UNDERTAKER H. L. Brown & Son ADDRESS 1617 N Monroe

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56510

D 56510

CERTIFICATE OF DEATH.

150

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6005 Foster ave ST.: 26 WARD)

2-FULL NAME Donald A Foreman

(a) RESIDENCE. No. 6005 Foster ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 29 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			one	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm A Foreman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Centreville Md

12 MAIDEN NAME OF MOTHER Eleanor Kilroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Govans Md

14 Informant .....
(Address) .....

15 AUG 30 1924 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1924, to Aug. 30, 1924, that I last saw him alive on Aug 30, 1924, and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart.

(duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Hoen, M. D.

8-30, 1924 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Cemetery Govans	Aug 31 1924
20 UNDERTAKER	ADDRESS
Johannah Candeo	976 Aisquith

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56511 64 D 56511

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2111 Westwood Ave. St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Damie

(Residence in Baltimore: No. 2111 Westwood Ave. St.) 15 yrs., X mos., X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White-Jew

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, X (Month) Unknown (Day), 18.. (Year)

7-AGE, About 53 yrs., or in. 53 mo. 11 ds.

If LESS than 1 day, X hrs. or X min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dave Damie

(Address) 2111 Westwood Ave

15- BOYER & KRAUTER

Filed AUG 30 1921 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 29th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11.00 A.M. 8-24 1921, to 8.45 P.M. 8-29 1921, that I saw her alive on Aug. 29th 1921, and that death occurred, on the date stated above, at 8.45 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

(Duration) X yrs. X mos. 1/2 ds.

CONTRIBUTORY (Secondary)

(Duration) X yrs. X mos. X ds.

(Signed) O. A. Hoffmann M. D.

8-29th, 1921 (Address) 3404 Walbrook Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rehrem Rosedale

DATE OF BURIAL, 8/30, 1921

20-UNDERTAKER Jack Levin

ADDRESS 1411 E Balt St

MARK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56512 64 D 56512

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1536 Brunt St ST.: 14 WARD)

2-FULL NAME Emma Groomes

(a) RESIDENCE. No. 1526 Brunt St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Groomes

6 DATE OF BIRTH (month, day, and year): Sept- 1862

7 AGE: Years 58 Months 10 Days - If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: John Groomes (Address) 1526 Brunt St

15 Filed AUG 30 1921 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1921, to Aug 24, 1921, that I last saw her alive on Aug 24, 1921, 3.30 a. m. and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinic

(Signed) Chas F. Lawrence M. D.

(Address) 1604 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cmty — DATE OF BURIAL: Aug 31 1921

20 UNDERTAKER: Geo H. Hollands — ADDRESS: 1631 Monroe St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D-56513

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37

D-56513

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 School ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Harding.

(a) RESIDENCE. No. 1520 School ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Harding

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	+	+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Laurelville Miss

PARENTS

10 NAME OF FATHER William Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Frank Harding 1520 School St.

15 AUG 30 1921

DOROTHY I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1921, to Aug 28, 1921, that I last saw h.. alive on Aug 28, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicoemia

(duration) + yrs. + mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dennal Symptoms

(Signed) Charles E. Clark M. D.

8-29, 1921 (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 8/31 1921

20 UNDERTAKER Geo French

ADDRESS Laurel Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL ... ARE RESERVED. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Executive Office

State of Maryland
Department of Health
DR WILLIAM H. WELCH, PRESIDENT
DR JOHN S. FULTON, SECRETARY
16 W. SARATOGA ST., BALTIMORE

STATE BOARD OF HEALTH
WILLIAM H. WELCH, M. D.
WILLIAM W. FORD, M.D.
C. HAMPSON JONES, M.D.
TOLLEY A. BIAYS
ALEXANDER ARMSTRONG
BENJAMIN C. PERRY, M. D.
E. F. KELLY, PHAR. D.
JOHN S. FULTON, M.D.

April 28, 1922.

Dr. Mary Sherwood,
City Health Department,
311 Courtland Street,
Baltimore, Maryland.

Dear Dr. Sherwood:

I enclose herewith original certificate of death for Mary Harding. As I fear it will be a long time before this case comes up in court, I do not wish to keep the certificate out of your files.

It might help to secure a more speedy trial if you will have Dr. Jones write to the State's Attorney, asking that the case be put on the docket at his earliest convenience.

Very truly yours,

J. Davis Donovan.

JDD:ahb

#D 56513

Spec.—6-9-19—H. P. Co.—1000 Blks.

D-56514

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-56514

REGISTERED NO. 479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 E. Lexington ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Diggs

(a) RESIDENCE. NO. 16 E Lexington ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Diggs

6 DATE OF BIRTH (month, day, and year) ~~Apl 1 1876~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
45	—	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Williamsport Pa

PARENTS

10 NAME OF FATHER Jacob Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Alice Diggs 16 E. Lexington St

15 Filed AUG 30 1924 [redacted] Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 . 1924 . to Aug 28 . 1924 .

that I last saw him alive on Aug 26 . 1924 .

and that death occurred, on the date stated above, at 6.10 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency (duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gustav Goldmann, M D

, 19 (Address) 1654 Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Cemetery — DATE OF BURIAL 8/30 1924

20 UNDERTAKER Jos. Gerhold & Son — ADDRESS 406 W. Lexington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fecal Accuracy

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-56515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-56515

~~D-56514~~

152

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (NO. Lombard & Greene ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Elizabeth Kirchner

(a) RESIDENCE. NO. 1836 Durham ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28 1921

7 AGE	Years	Months	Days	If LESS than 1 day 13 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Benedict Kirchner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary Decker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mary Kirchner (Mother)
(Address) 1836 Durham St.

15 Filed AUG 30 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1921

17 I HEREBY CERTIFY, That I attended deceased from August 28, 1921, to Aug 29, 1921, that I last saw h[illegible] alive on Aug 29, 1921, and that death occurred, on the date stated above, at 12.50 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (

(Signed) Hilborn Rose M. D.

8/29, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Aug 31 1921
20 UNDERTAKER Lilly & Zieler	ADDRESS 403 S Wolfe

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 56516 — 56516 — D 56516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 167

1-PLACE OF DEATH
CITY OF BALTIMORE (No. John Hopkins Hospital WARD 5)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Levin

(Residence in Baltimore: No. 250 N. Exeter St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Feb — (Month), ... (Day), 1910 (Year)

7-AGE, 10 yrs. 6 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Joseph Levin

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Ida Silver

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. Levin

(Address) 250 N. Exeter St.

AUG 30 1921

Filed ....., 191.. ROBERT P. PRATER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 27 (Day), 1911 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns. Shock

Sepsis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

8-31, 1911. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hebrew Rituals	Aug 30 19 21

20-UNDERTAKER Jack Levin, 411 E. Balto St.

ADDRESS

Spec. 6-9-19 H. P. Co. 1000 Blks.

148761

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56517

D 56517 CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.: [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Cooper

(a) RESIDENCE. No. 611 St Joseph St. St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steel Plate Worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: David Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Jane Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): John Hopkins Hospital

15 Filed AUG 30 1921 ROBERT I. [illegible]

Burial Permit Oleo

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10. 1921. to Aug 30. 1921.
that I last saw h[illegible] alive on Aug 30. 1921.
and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Rupture aneurysm arch of aorta

(duration) yrs. 8 mos. [illegible] ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? Yes Date of 7-16-21

Was there an autopsy? Yes.

What test confirmed diagnosis? X Ray Autopsy

(Signed) Emil Hellman, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] HOPKINS HOSPITAL

DATE OF BURIAL: [illegible] 192

20 UNDERTAKER: Commissioner Health

ADDRESS: [illegible] MG

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

56518

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56518

CERTIFICATE OF DEATH.

D 56518

61-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hosp — ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel Hutchinson

(a) RESIDENCE. No. Nursery & Child's Hosp ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch - 1920 (?)

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	6 ?		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co - Md -

PARENTS

10 NAME OF FATHER Louis Hutchinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Lucy Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant
(Address)

15 Filed AUG 30 1921 ROBERT F. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 18 - . 1921 . to Aug. 29 - . 1921 .

that I last saw her alive on Aug 29 - . 1921 .

and that death occurred, on the date stated above, at 7.45 p. m.

The CAUSE OF DEATH* was as follows:

~~Tuberculosis~~ Pandysentery

Endemic Fever typhoid Final Hemorrhage due to Septicemic type

Edgar Hutchinson (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Stool & Urine from Laboratory findings

(Signed) Isaac H. Jones M. D.

. 19 (Address) 1000 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: Aug 30 1921

20 UNDERTAKER: Commissioner Health

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-1-19—H. P. Co.—1(Bks.

HEALTH DEPARTMENT—CITY OF BALTIM[illegible] E D 56519

CERTIFICATE OF DEATH.

D 56519

REGISTERED NO. 154

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1008 Aisquith. St. ST.: 10 WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna. Lorenz.

(a) RESIDENCE. No. 1008 Aisquith. St. ST., 10 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The late Anthony. J. Lorenz

6 DATE OF BIRTH (month, day, and year) May. 21. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George. A. Schafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Rev. J. A. Lorenz. (Address) Philadelphia. Pa.

15 Filed AUG 30 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29. 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st. 1921, to Aug. 29. 1921, that I last saw h[illegible] alive on Aug. 29 1921, and that death occurred, on the date stated above, at 8.15 P. M. a.m.

The CAUSE OF DEATH* was as follows:

Oedema pulmonum

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. J. Sebold, M. D.

Aug. 30 1921 (Address) 1001 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Sept. 2 1921

20 UNDERTAKER Henry Horck Son

ADDRESS 1301 E Eager St

IMPORTANT.—THIS CERTIFICATE should be carefully supplied. All items should be stated EXACTLY. Exact statement should be properly classified. Exact statement may be properly classified. Exact statement may be properly classified. Exact statement may

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56520

CERTIFICATE OF DEATH.

D 56520

REGISTERED NO. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 318 S. Clinton ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Christena Milke

(a) RESIDENCE. NO. 318 S. Clinton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Henry J. Milke

6 DATE OF BIRTH (month, day, and year) Dec. 15-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home (none)

(b) General nature of industry, business, or establishment in which employed (or employer) none 037

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Caspar Luckhardt

11 BIRTHPLACE OF FATHER (city or town) not known (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Hutzog

13 BIRTHPLACE OF MOTHER (city or town) not known (State or country) Germany

14 Informant Mrs. Clara M. Ritter (daughter) (Address) 318 S. Clinton St.

15 Filed Aug 30 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from ——, 1910, to Aug 29, 1910, that I last saw h[er] alive on Aug 29, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 10+ yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia (coma)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Urinalysis

(Signed) [illegible], M. D.

8/30 1921 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetary

DATE OF BURIAL Aug. 31 1921

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager

Information should be carefully supplied. AGE should be properly classified. Exact statement may be necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56521

D 56521

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Warezniki

(a) RESIDENCE. No. 2641 Hudson St. ST., WARD. St. James 10 A

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	M.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(h) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Adam Bekzinski

(Address) 1917 Back St

15 Filed Robert P. Harrison, Registrar

3 01921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1921, to August 28, 1921.

that I last saw h.im alive on Aug 28, 1921.

and that death occurred, on the date stated above, at 6.10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

and Apoplexy (duration) yrs. mos. 8 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Aug 31 1921
20 UNDERTAKER	ADDRESS
Stephen L Falkowski	1005 S Ken

WRITE PLAINLY. Use only black or blue-black ink. Fill in all the items. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: [illegible] Ward)

REGISTERED NO. 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Gardner

(a) RESIDENCE. No. 127 N 20th St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Solomon Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Dickins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18 - 1921. to Aug 28 - 1921.
that I last saw h[illegible] alive on Aug 28 - 1921.
and that death occurred, on the date stated above, at 7 00 P. m.
The CAUSE OF DEATH* was as follows:

Bacillary dysentery

(duration) yrs. mos. 18 ds.

CONTRIBUTORY — (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Stool culture

(Signed) [illegible] M. D.
Aug 30, 1921 (Address) J H H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Aug 30 1921
20 UNDERTAKER	ADDRESS
Samuel Kemsley	[illegible]

W.—WRITE PLAINLY, WITH INK. All questions should be answered. Exact statement of date of birth, age, and place of death should be stated. Information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Information on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56523

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 W. Saratoga St. ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Olivia Williams

(a) RESIDENCE. No. 1604 W. Saratoga St. ST., 19th. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negree	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Williams

6 DATE OF BIRTH (month, day, and year) Dec. 8-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co. (State or country) Md

PARENTS

10 NAME OF FATHER William Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va. ?

12 MAIDEN NAME OF MOTHER Sarah Mathews

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co. (State or country)

14 Informant Arthur Williams (Address) 1604 W. Saratoga St.

15 Filed Aug 30 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29/'21. 19

17 I HEREBY CERTIFY, That I attended deceased from Aug. 18th. 19 to Aug. 29th. 19, that I last saw her alive on Aug. 29th. 1921. 19, and that death occurred, on the date stated above, at 8: 20 p m.

The CAUSE OF DEATH* was as follows:

Acct. Peritonitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Ch. Appendicitis

(duration) 1 ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Aug 31 19

20 UNDERTAKER Samuel K. Ramsey ADDRESS 378 N. Bolle

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY in years, months and days. Exact statement of occupation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

D 56524

D 56524

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 W. Saratoga ST.: 14 WARD)

2-FULL NAME Mary E. Carroll

(a) RESIDENCE. NO. 1419 W. Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Sinclair S. Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Emily White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ellicott City Md.

14 Informant William S. Carroll
(Address) 1419 W. Saratoga St

15 Filed Robert P. Harrison, Registrar
AUG 30 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 15 1921, to Aug 30 1921
that I last saw h alive on Aug 29 1921,
and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

osteo Sarcoma of Tibia (right leg)

(duration) — yrs. 8 mos. 10 ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jefferis Bucy M. D.

Aug 30 1921 (Address) 2846 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 1 1921

20 UNDERTAKER ADDRESS
Chas. G. Black 742 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56525 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56525

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 109 N Carlton ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Smith

(a) RESIDENCE. NO. 109 N Carlton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Wm. Leonard Smith

6 DATE OF BIRTH (month, day, and year): March 4, 53

7 AGE — Years: 68 — Months: 5 — Days: 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Talbert County Md.

PARENTS

10 NAME OF FATHER: James Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Carrie Coleman

(Address): 109 N Carlton St.

15 Filed AUG 30 1921 Robert P. Harrison, Registrar

Burial ~~Permit~~ Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/29/1921

17 I HEREBY CERTIFY, That I attended deceased from August 22 1921, to August 29, 1921, that I last saw her alive on August 29, 1921, and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Valvulitis

(duration) Indef. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Howell M. D.

8/29/1921 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL: Aug 31 1921

20 UNDERTAKER: Brandenburg Funeral Home ADDRESS 1440 W Lexington St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56526

CERTIFICATE OF DEATH.

37

D 56526

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 S. Charles ST., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry James

(a) RESIDENCE NO. 504 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Marie James

6 DATE OF BIRTH (month, day, and year) ——— 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Henry James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Sallie Pennington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Marie James

(Address) 504 S. Charles

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

UG 30 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated in every case where information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. IT IS VERY important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug, 29, 1921

17

I HEREBY CERTIFY, That I attended deceased from July, 5, 1921, to Aug, 29, 1921.

that I last saw him alive on Aug, 28, 1921,

and that death occurred, on the date stated above, at 4, 15 A, m.

The CAUSE OF DEATH* was as follows:

Aortic Aneurism

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) unknown ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? at J. H. Hospital Aug

(Signed) David Frankling M. D.

(Address) 122 W. Lee St 8/30 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 31 1921
20 UNDERTAKER	ADDRESS 114 N.
Brown & Rutland.	Calhoun St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56527

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56527

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2702 Fenwick ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Katharine Snyder

(a) RESIDENCE. NO. 2702 Fenwick ST., 9 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 9 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa

12 MAIDEN NAME OF MOTHER Mary Lusby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md

14 Informant Miss Katharine Snyder (Address) 2702 Fenwick Ave

15 Filed AUG 30 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1921, to Aug 29th, 1921, that I last saw h.e alive on Aug 29, 1921, and that death occurred, on the date stated above, at 3, 30 P m.

The CAUSE OF DEATH* was as follows:

Indigestion Acute

5 hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman, M. D.

, 19 (Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Sep 1 1921

20 UNDERTAKER: Henry Lutz — ADDRESS: 1007 N. Bond

N. B.—WRITE mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56528

170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Whittier Ave ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara A. Martin

(a) RESIDENCE NO. 2311 Whittier Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Martin

6 DATE OF BIRTH (month, day, and year) Jan 18, 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
57	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eckert Md.

PARENTS

10 NAME OF FATHER Francis Mawrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Peter Martin

(Address) 2311 Whittier Ave

15 Robert F. [illegible]

Filed ....., 19 .....

0G3 01921 Burial Permit Clerk. Registrar

N. B.—WRITE PLAINLY. All information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly classified. Date of TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug, 30 1921

17

I HEREBY CERTIFY, That I attended deceased from July, 10, 1920, to Aug, 30, 1921, that I last saw h. W alive on Aug, 29, 1921, and that death occurred, on the date stated above, at 12, 10a/m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. - mos - ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Chronic Interstitial Nephritis (duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dan Smuckler, M. D.

8/30, 1921 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland, Md.

DATE OF BURIAL 19

20 UNDERTAKER Wm J. Tuckerman Sons

ADDRESS North & Pa

Spec.—1-10-21 M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56529

D 56529

CERTIFICATE OF DEATH.

REGISTERED NO. 43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 W Lafayette ave ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Rhoads

(a) RESIDENCE NO. 1207 W Lafayette Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ~ 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of Industry, business, or establishment in which employed (or employer) Public Schools

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas H Rhoades

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E McElhenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Rhodes
(Address) 1207 W Lafayette Ave

15 Filed AUG 30 1921 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29. 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Aug 29, 1921,

that I last saw h alive on Aug 29, 1921,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cancer of breast

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Jan 3 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. E. Plummer M. D.

19 (Address) 1601 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loyola Mt Cem

DATE OF BURIAL 19 21

20 UNDERTAKER H. Thanhauser Sons

ADDRESS Baltimore

N. B.—WHITE should be carefully supplied. Age mation should be carefully supplied. Exact information CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Frank Nowroski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56530

D 56530

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 708 S Bond ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Nowroski

(a) RESIDENCE. NO. 718 S Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Kowalczewska

(Address) 708 S Bond

15 Filed AUG 30 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/29 1921, to 8/29 1921,

that I last saw him alive on 8/29 1921,

and that death occurred, on the date stated above, at 1930 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & symptoms

(Signed) Jay A Anthrop, M. D.

8/30. 1921 (Address) 1625 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Rosary aug 31 1921

20 UNDERTAKER — ADDRESS

John M Weber 1803 Bank

N. B.—WRITE PLAINLY, WITH CARBON PENCIL. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56531

D 56531

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sophia Olegewska

(a) RESIDENCE. No. 803 Dallas St ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, New City Hospital.

15 Filed AUG 30 1921, 19 Registrar: Robert F. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 30 1921

17 I HEREBY CERTIFY, That I attended deceased from August 26, 1921, to August 30, 1921

that I last saw her alive on August 29, 1921

and that death occurred, on the date stated above, at 6:55 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Bay View

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde A. Merrill, M. D.

8/30/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Sept 1 1921

20 UNDERTAKER	ADDRESS
John A. Weber	1803 Bank

mation should be carefully supplied. Any
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec.—6-3-19—H. P. Co.—1000 Bks.

D 56532 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56532

CERTIFICATE OF DEATH. 120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1050 W. Fayette St. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. Kuhl

(a) RESIDENCE. NO. 1050 W. Fayette St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George W. Kuhl

6 DATE OF BIRTH (month, day, and year): Sept. 20th 1843

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Mr. Henrickle

11 BIRTHPLACE OF FATHER (city or town) (State or country): U. S.

12 MAIDEN NAME OF MOTHER: Ellen Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co. Md.

14 Informant (Address): J. George Reese 1050 W. Fayette St.

15 Filed , 19 Robert P. Harrison, Registrar

G 3 01921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 28th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 , 1921 , to Aug 27 , 1921 ,

that I last saw h[illegible] alive on Aug 27 , 1921 ,

and that death occurred, on the date stated above, at 4.40 A.m.

The CAUSE OF DEATH* was as follows:

Uterine Utremic Coma

(duration) 12 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. F. Long, M. D.

, 19 (Address) 902 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 31st 1921
20 UNDERTAKER: Joseph B. Cook	ADDRESS: 1003 W. Baltimore St.

CAUSE OF DEATH to be filled in plainly and completely. See instructions on back of certificates. ATTENTION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 56533 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56533

40

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1901 E Chase ST., 2 WARD)

2-FULL NAME John H Farrall

(a) RESIDENCE NO. 1901 E Chase ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mab

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Mary M Farrall

6 DATE OF BIRTH (month, day, and year): Sept 11-1856

7 AGE: Years 65 Months Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Car Inspector

(b) General nature of industry, business, or establishment in which employed (or employer): Railroad

(c) Name of employer: B & O Charlestown Md

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary M Farrall (Address) 1901 E Chase St

15 1921 Aug 30 Robert P. Harrison, Registrar

Julius Friedenwald Co. Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 29 1921

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1920, to Aug 29, 1921, that I last saw h... alive on Aug 25, 1921 and that death occurred, on the date stated above, at 2 30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

About (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray.

(Signed) Rodney P. Harrison, M. D.

, 19 (Address) 1013 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salem Lutheran Catonsville — DATE OF BURIAL Aug 31 1921

20 UNDERTAKER: W. Calvert Nathan — ADDRESS

N.B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements on back of certificates. See instructions on back of certificates. This is very important.

Spec.—4-9-19—H. P. Co.—1000 Bks.

D 56534

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56534

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 N. Bradford ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Rubran

(a) RESIDENCE. NO. 104 N. Bradfrod ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Rubran

6 DATE OF BIRTH (month, day, and year) August 15th 1842

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	79		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Imogen ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fredericka Taylor

(Address) 104 N Bradford St

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 29th 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 18th, 1921, to August 29th, 1921, that I last saw her alive on August 29th, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Metoal Regurgitation

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J Russell, M. D.

, 19 (Address) 1127 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 31 1921

20 UNDERTAKER Wm. C. Miller

ADDRESS 2334 Jeffrey St

S. B.—BIRTH mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

G3 01921

Spec.—1-10-21—M&T—1500 Bks.

D 56535

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56535

CERTIFICATE OF DEATH.

28

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 N. Chapel ST., 7 WARD)

2-FULL NAME Joseph H Hawkins

(a) RESIDENCE NO. 602 N. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hawkins

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook (2)

(b) General nature of industry, business, or establishment in which employed (or employer) Merchants & Miners

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Isaac Hawkins

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) A A Co Md

12 MAIDEN NAME OF MOTHER Mary J Purton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Isaac Hawkins (Address) 613 N. Bradford St

15 Filed ..... 19 ..... Registrar

Robert F. Harrison,

AUG 3 01921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1921, to Aug 29, 1921, that I last saw h. alive on Aug 27, 1921, and that death occurred, on the date stated above, at 12 20 P.M.

The CAUSE OF DEATH* was as follows:

Senile Anaemia

born

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) asthma (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W J Rouke, M. D.

19 (Address) 1904 E. Lafayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leakin Park Cem

DATE OF BURIAL Aug 31st 1921

20 UNDERTAKER James M. Skinner

ADDRESS 1620 E. Baltimore St

N. B.—WRITE mation should be carefully supplied. ALL CAUSE OF DEATH in plain terms, so that it may be properly classified. Data TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tuberculosis
had only seen him once
& could get no history

D 56536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56536

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital ST.: 25 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Spindler

(Residence in Baltimore: No. Halethorpe md St.; yrs., mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word)
Male	white	single

6-DATE OF BIRTH, ... (Month) ..... (Day), 1909 (Year)

7-AGE, 12 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Halethorpe Md

PARENTS.

10-NAME OF FATHER, Valentine Spindler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbara Brech

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Valentine Spindler

(Address) Halethorpe Md.

15- AUG 31 1921 Filed ....., 191.... ROBERT I. KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 28, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull and Contusion of Brain Accident

(Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Septic Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) James M. Renton M. D. (Coroner.)

Aug. 29, 1921 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 11 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Halethorpe md

Former or usual residence Halethorpe Md

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Aug. 31st, 1921.

20-UNDERTAKER ROBERT BROOKS & SON ADDRESS 175 Baltimore St

N. B.—Every item of information should be carefully supplied. AGE in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56537

CERTIFICATE OF DEATH.

64

D 56537

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 662 Dover ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Sanks

(a) RESIDENCE. No. 662 Dover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Sanks

6 DATE OF BIRTH (month, day, and year) Unknown 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Sanks (Address) 662 Dover St

15 Filed AUG 31 1921 19 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1918, to Aug 27, 1921, that I last saw h alive on 19, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows: Paralysis Arterial Sclerosis

(duration) 3 yrs. 8 mos. 6 ds.

CONTRIBUTORY (Secondary) As Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. B. Gibbons M. D.

19 (Address) 712 S Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Sept 1 1921

20 UNDERTAKER John N. Toadvine ADDRESS 1142 Druid St

N. B.—All information should be carefully supplied. Any omission may be properly classified. Exact information is required. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is required. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56538 105 C 56538

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

D 56538

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 756 George ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Battle St.: ....yrs., ...mos. ....ds.)

(Residence in Baltimore: No. 756 George St

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Female	Colored	Single

6-DATE OF BIRTH, Dec (Month) 2 (Day) 1918. (Year)

7-AGE, 2 yrs. 8 mos. ....da. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work ..... (b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Richard Battle

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Evelyn Hynn

13-BIRTHPLACE OF MOTHER (State or Country), E Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Hammond

(Address) 756 George St.

15- AUG 31 1921 BOARD OF HEALTH

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 30 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30th 1921, to Aug 30th 1921, that I saw h[illegible] alive on Aug. 30th 1921 and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows. Gastro-enteritis

(Duration) ....yrs. ....mos. 3 da.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....da.

(Signed) A. Lee Ellis M. D.

8-30-, 1921 (Address) 924 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Sept 1, 1921

ADDRESS 916 Eo Ave

20-UNDERTAKER Daniel Easton

N. B.—Every item of information must be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56539

D 56539

CERTIFICATE OF DEATH.

REGISTERED NO. 43

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 Wilmore Alley ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Mary Davis

(a) RESIDENCE NO. 916 Wilmore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John W Evans (Address) 916 Wilmore Alley

15 Filed AUG 31 1921 19 ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to August 30 1921, that I last saw her alive on August 29, 1921, and that death occurred, on the date stated above, at 7.35 A.m.

The CAUSE OF DEATH* was as follows:

Apoplexy + Gangrene

Carcinoma of Breast (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast (duration) yrs. 8 mos. 11 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno W Kennard M. D.

8-30, 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Aug 1921

20 UNDERTAKER Daniel Easton

ADDRESS 916 Paca

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be properly classified. Exact statement of information should be carefully supplied. AGE should be carefully classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Form 6-9-19—H. P. Co.—1000 Blks.

D 56540

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56540

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST.: 19 WARD)

2-FULL NAME Mary Middley

a) RESIDENCE. NO. 1705 W. Franklin ST.. ..... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negress	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Phillip Middley

6 DATE OF BIRTH (month, day, and year) Dec. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63 yr.	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Middley (?)

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Virginia

12 MAIDEN NAME OF MOTHER Mary (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) Virginia

14 Informant Phillip Middley
(Address) 1705 W. Franklin St.

15 Filed AUG 31 1921 19 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29th 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug. 25 , 1921 , to Aug. 29 , 1921 ,

that I last saw her alive on Aug. 29 , 1921 ,

and that death occurred, on the date stated above, at 12 25 a m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia (lower 2 lobes right lung) (duration) yrs. ..... mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F. A. Riley , M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 31 1921
20 UNDERTAKER David Eastard	ADDRESS 916 Pa Ave

N. B.—WRITE plainly and be careful to have all information should be carefully supplied. Any erasure may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Coste

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56541 ✓ D 56541

28

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2456 Buchanan ST.; 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winfield Coste

(Residence in Baltimore: No. 2456 Buchanan St.; 7 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Cl

5-~~SINGLE~~ MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, 9 (Month) 1 (Day), 1895 (Year)

7-AGE, 26 yrs. 11 mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Henry Coste

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Winnie Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Coste

(Address) 2456 Buchanan

15- ROBERT J. KRAUTER

Filed AUG 31 1921, 191.... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 29 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 9 1921, to Aug 29 1921, that I saw h- alive on Aug 29 1921, and that death occurred, on the date stated above, at 4h. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Gabriel Chenault M. D.

Aug 30, 1921 (Address) 1534 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Aug 31 1921

UNDERTAKER, Samuel Hemsley

ADDRESS 5781 Reisterstown Rd

N. B.—Every item of information must be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D 56542

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

174

REGISTERED No. C

D 56542

1 PLACE OF DEATH

CITY OF BALTIMORE (No.) Krem Hospital (ST.) 13 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.))

2 FULL NAME Joseph Castleberg

(Residence in Baltimore: No. Emerson ave E. St. yrs. 57 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Jewelry Merch't
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jacob Castleberg

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Emmy Rodberg

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Saml Heller

(Address) Revere opt

15-

Filed ....., 191.. Burial ..... Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 30 (Day) 191.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Laceration of aorta

Instantaneous (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner)

Sept 6 1911 (Address) ..... M.D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship Cem. DATE OF BURIAL, Sept 1. 1911

20-UNDERTAKER J Ehrens & Bro ADDRESS 1611 Madison Av

N. B.—Every item of information should be carefully supplied. AGE must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56543

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56543

CERTIFICATE OF DEATH.

REGISTERED NO. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) #3729 Park Heights (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Amelia Horstein

(a) RESIDENCE. NO. #3729 Park Heights ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If married, widowed, or divorced (or) WIFE of Nathan Horstein

6 DATE OF BIRTH (month, day, and year) Aug 17, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Horstein Germany

PARENTS

10 NAME OF FATHER Oscar Emmrich

11 BIRTHPLACE OF FATHER (city or town) Horstein (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Mrs. F. Goldenberg (daughter) (Address) #3729 Park Heights

15 Filed . 19 Hospital Records (Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1921, to Aug. 29, 1921, that I last saw her alive on Aug. 29/21. 19 , and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 16 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Hutchcraft, M. D.

, 19 (Address) 1352 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Sholom Cem — DATE OF BURIAL: 8/31 1921

20 UNDERTAKER: J. Ahrens Co — ADDRESS: 1611 Madison

N. B.—[illegible] should be carefully supplied. AGE should be properly classified. Exact statement of occupation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may

Spec.—1-10-21—M&T—1500 Bks.

Glenmore Lee.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56544 — 1521 — 8838.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1435 N Mount St. (ST.) 15 (WARD)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Glenmore Lee

(a) RESIDENCE NO. 1436 N Mount St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	38	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 035

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Wesley Lee

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Edwards

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Gertrude Lee

(Address) 1435 N Mount St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16 1921 to Aug 30 1921.

that I last saw him alive on Aug 29 1921.

and that death occurred, on the date stated above, at 2.25 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart

(duration) Undetermined yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms Mitral regurgitation

(Signed) Charles E. Cleary M. D.

(Address) 1306 N. Johnson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St John the Baptist Church Cem DATE OF BURIAL Sept 3rd 1921

20 UNDERTAKER Clarence E Wright ADDRESS 1647 Mc Cam

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Duplicate certificates. TION is very important. See instructions on back of certificates.

B 56545

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 56545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH ~~In Grey Harper~~ 17th

CITY OF BALTIMORE (No. 1410 ~~Darley Ave~~ ST.; 9 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Haltham.

(Residence in Baltimore: No. 1410 Darley ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH. August. 29, 1908
(Month) (Day) (Year)

7-AGE. 13 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer). Pupil

9-BIRTHPLACE, (State or Country). Balt md.

PARENTS.

10-NAME OF FATHER. Albert Haltham.

11-BIRTHPLACE OF FATHER (State or Country). Balt md.

12-MAIDEN NAME OF MOTHER. Minnie Rembenkoning

13-BIRTHPLACE OF MOTHER (State or Country). Balt md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. Haltham

(Address) 1410 Darley ave

15- ROBERT J. KRAUTER

Filed ....., 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH May 28, 191..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia fol
Influenza
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)
[illegible], 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Emanuel Cemetery Laurel

DATE OF BURIAL. May 31, 1912

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Hanford ave.

N. B.—Every item of information should be carefully supplied. ~~Avoid~~ CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spmc—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56546

D 56546

CERTIFICATE OF DEATH.

84

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Edward Norton

(a) RESIDENCE. No. 1821 Brunt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER William Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Margaret Norton
(Address) 1821 Brunt St

15 Filed . 19 Registrar

Burial Permit Clerk

AUG 31 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 27. 1921. to Aug. 30. 1921.
that I last saw him alive on Aug. 30. 1921.
and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 27, 192

Was there an autopsy? No.

What test confirmed diagnosis? Signs & Symptoms

(Signed) C Samuels, M. D.

. 19 (Address) 1928 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spare.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 19
20 UNDERTAKER Marlow Fahey & Sons	ADDRESS 1211 W Fayette St

mation should be carefully supplied, so that it may be pr
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of cert

Bettie Hurstte

56547

HEALTH DEPARTMENT—CITY OF BALTIMORE

56547

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 338 Dover ST. 72 WARD)

REGISTERED No. C 10 4

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Bettie Hurstte

(Residence in Baltimore: No. 338 Dover St - St.; yrs., mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, 8 (Month) 10 (Day), 121 (Year)

7-AGE, ...yrs. 20 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country). Balto city

PARENTS.

10-NAME OF FATHER, Thomas Hurstte

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Edna Magruder

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Magruder

(Address) 338 Dover

15-

Filed ....., 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ....~~Physician~~ Jury ....find that said deceased came to ~~his~~ her death ~~by~~ on the day stated above.

~~autopsy or~~ inquiry.)

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. 14 ds.

(Signed) W B Gonce M. D. (Coroner.)

8.31, 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Ct. DATE OF BURIAL, Aug 31, 1921

20-UNDERTAKER Isaiah S. Brown & Son ADDRESS 1050 Montgomery St

N. B.—Every item of information should be given as accurately as possible, so that it may be properly examined. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56548

CERTIFICATE OF DEATH.

91 ✓

56548

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 N. Vincent ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Anderson

(a) RESIDENCE. No. 1106 N. Vincent ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	one	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. City
(State or country) Inst.

PARENTS

10 NAME OF FATHER Norman Anderson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Rose Simms

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Howard Co. Md.

14 Informant Norman Anderson
(Address) 1106 N. Vincent

15 Filed AUG 31 1921 ROBERT J. KRAFFT Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1921, to Aug. 29, 1921, that I last saw her alive on Aug. 28, 1921, and that death occurred, on the date stated above, at 5-40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Clinical symptoms.

What test confirmed diagnosis?

(Signed) Chas. L. McCarthy, M. D.

, 19 (Address) 906 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 31 1921

20 UNDERTAKER Edward Ruggold ADDRESS 1463 N. Carey

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56549 56549

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2924 Riggs Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace R. Tanner.

(Residence in Baltimore: No. 2924 Riggs Ave St.; ... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June, 1886
(Month) (Day) (Year)

7-AGE, 35 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stenographer 886.
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm C Tanner

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emma Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma C Tanner

(Address) 2924 Riggs Ave

15-

Filed ..., 191...

Registrar.

AUG 31 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1919, to Aug 29 1921, that I saw h[illegible] alive on Aug 29 1921, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary and Laryngeal Tuberculosis

(Duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY ...
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Joseph N Zierler M. D.

Aug 30, 1921. (Address) 1003 Eutaw Street.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL, OR REMOVAL. London Park

DATE OF BURIAL. Sept 1 191 21

20-UNDERTAKER E Clark Tanner Inc

ADDRESS 1XX W Mulberry

N. B.—Every item of information called for in this certificate is important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be classified.

D 56550

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56550

CERTIFICATE OF DEATH.

151

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 229 S. Ann St. ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Hanesh

(Residence in Baltimore: No. 229 S Ann St.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Infant

6-DATE OF BIRTH, August 18, 1921.
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 12 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE. (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Anthony Hanesh

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Marie Wagner

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Hanesh

(Address) 229 S. Ann St.

15-

Filed AUG 31 1921 ROBERT I KRAUTH Registrar.

Burial Permit Issued

N. B.—Every item of information should be carefully supplied. Each item must be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 30, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

8/31/21, 191.. (Address) 1600 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Most Holy Redeemer — DATE OF BURIAL, August 31 1921

20-UNDERTAKER Wendell Chapel & Son — ADDRESS 37 S. Caroline

D 56551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56551

CERTIFICATE OF DEATH.

REGISTERED NO. C 151

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 229 E Lem St. ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Lausch.
(Residence in Baltimore: No. 229 E. Lem St.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Infant

6-DATE OF BIRTH, August 18, 1921.
(Month) (Day) (Year)

7-AGE, yrs. mos. 12 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER, Anthony Lausch
11-BIRTHPLACE OF FATHER (State or Country), Baltimore Maryland
12-MAIDEN NAME OF MOTHER Mamie Wagner
13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anthony Lausch
(Address) 229 E Lem St.

15- ROBERT J. KRAUTER
Registrar.
Burial Permit
AUG 31 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 30, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Congenital Debility
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) Thomas Ligue M. D.
(Coroner)
8/31/21 (Address) 1100 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Most Holy Redeemer
DATE OF BURIAL, August 31 1921.
20-UNDERTAKER Wendell A. Lippe
ADDRESS 32 E Lem St

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. Exact statement of [illegible] important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56552

CERTIFICATE OF DEATH.

REGISTERED NO. C 1201

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Hebrew Hospital. ST.; 19 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Ginsburg
(Residence in Baltimore: No. 230 N. Vincent St. City St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, White.
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 17 (Day), 1886 (Year)

7-AGE, 35 yrs. mos. ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Simon Ginsburg
11-BIRTHPLACE OF FATHER (State or Country), Russia
12-MAIDEN NAME OF MOTHER Fanny Lazaroff
13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. A. Ginsburg
(Address) 1411 E. Balto. St.

15- Filed Aug 31 1921, 191... Registrar.

N.B.—Every item of information should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms. All items important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 28 1921, to Aug 30 1921, that I saw her alive on Aug 30 1921, and that death occurred, on the date stated above, at 10 11 m.

The CAUSE OF DEATH* was as follows:
Myocardial failure
Bronchopneumonia, influenza
Generalized Arteriosclerosis
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic nephritis
(Duration) yrs. mos. ds.

(Signed) Ernest Edlavitch M. D.
Aug 30, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. 3 ds. In the State Life yrs. mos. ds.
Where was disease contracted, if not at place of death? ?
Former or usual residence 230 N. Vincent St.

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, Aug 31, 1921.
20-UNDERTAKER Jack Levis, ADDRESS 1411 E. Balto.

AUG 31 1921
ROBERT J. KRAUTER
Registrar.
Burial Permit Clerk

Spec.—5-19-13—M. & T.—500 Bks.

Wm R. Delgar.

D 56553

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

D 56553

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 Chilham Road ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Robert Delgar

(Residence in Baltimore: No. Chilham Road St.: 10 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August 16, 1870 (Month) (Day) (Year)

7-AGE, 51 yrs. 0 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....mts.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Gentlemans Clothing

9-BIRTHPLACE, (State or Country), Sumter S.C.

PARENTS.

10-NAME OF FATHER, Wm Robert Delgar

11-BIRTHPLACE OF FATHER (State or Country) Charleston S.C.

12-MAIDEN NAME OF MOTHER Margaret Saunders

13-BIRTHPLACE OF MOTHER (State or Country), Sumter S.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm R. R. Delgar

(Address) 27 Washington

AUG 31 1921

Filed ....., 191.. Burial Permit Issued.

ROBERT J. BRAUTER

N. B.—Every item of information should be carefully given, as CAUSE OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 29, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1921, to Aug 29 1921, that I saw him alive on Aug 29 1921, and that death occurred, on the date stated above, at 7.16 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage 6

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) William L. Todd M. D.

Aug 30, 1921. (Address) 27 Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Ridge

DATE OF BURIAL, Aug 31, 1921

20-UNDERTAKER A S Marshall

ADDRESS 3539 Fall Rd

D 56554 D 56554

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1427 West st ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Lewis

(a) RESIDENCE. NO. 1427 West st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	B	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER Dennis Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co

12 MAIDEN NAME OF MOTHER Madlane Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co

14 Informant Daughter Alice Warner

(Address) 1427 West St

Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4 1921. to Aug 24. 1921.

that I last saw h alive on Aug 24. 1921.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Th.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) P. S. Hamilton, M. D.

8/30, 1921 (Address) 733 argyle st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laural Cemetery

DATE OF BURIAL: Aug 31 1921

20 UNDERTAKER: Wm Robert & Elliott

ADDRESS 1725 Eutaw st

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information stated EXACTLY as known. AGE should be stated properly classified. Exact statement of occupation should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56555

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 548 (Baker) ST.: 14 (Ward)

REGISTERED NO. 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Porter

(a) RESIDENCE. No. 548 Baker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fr

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): (Widow)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 1, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Out

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mrs Williams
(Address) 548 Baker St

15 Filed . 19 Registrar

AUG 31 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/30 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/11 1921 to 8/30 1921

that I last saw h alive on 8/30 1921

and that death occurred, on the date stated above, at 7 45 A m.

The CAUSE OF DEATH* was as follows:

Ac Jaundice - en Centr

+

Bloody Dysentery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burgh Cutler M. D.

. 19 (Address) 2159 D St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Sept 1st 1921
20 UNDERTAKER	ADDRESS
Groh & Holland	1631 Mad Holland

CAUSE OF DEATH in plain terms, TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56556

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 56556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 308 Fremo ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

½-FULL NAME Mary L. Clopein

(a) RESIDENCE. No. 308 Fremo ST. 20th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 9 mos. 19 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Clopein

6 DATE OF BIRTH (month, day, and year) Nov 10th 1878

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
42	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - Md

PARENTS

10 NAME OF FATHER Dallas Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Lydia Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Peter Clopein (Address) 308 Fremo St

15 Filed ..... 19 ..... Registrar

AUG 31 1921 Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-29 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/26 . 1921 . to 8/29 . 1921

that I last saw h[illegible] alive on 8/29 . 1921

and that death occurred, on the date stated above, at 2 [illegible] p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Tbc. spine & hip

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Newton D. Parr, M. D.

. 19 (Address) 1530 N. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery DATE OF BURIAL: Sept 1 1921

20 ~~UNDERTAKER~~ J B Kuppert ADDRESS 2236 Frederick av

mation should be given in plain terms, so that it may be properly coded. CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 56557

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1335 N. Bond ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. C. Briscoe

(a) RESIDENCE. NO. 1335 N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Alverta Briscoe

6 DATE OF BIRTH (month, day, and year) August 28th, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Cleaner 073

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer Western Maryland R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William D. Briscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sally Carrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Alverta Briscoe
(Address) 1335 N. Bond St.

15 Filed AUG 31 1921, 19 ROBERT J. KRAMER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to Aug 29, 1921.
that I last saw him alive on Aug 29, 1921.
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Failure of Compensation
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical —

(Signed) J. Walter Thomas, M. D.

(Address) 1228 N Caroline

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 1st 1921

20 UNDERTAKER Bertram W. Cook ADDRESS 1729 W Lafayette Ave

mation should be carefully answered, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

126 D 56558

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2621 Guilford Ave ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Rohde

(a) RESIDENCE NO. 2621 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Andrew Rohde

6 DATE OF BIRTH (month, day, and year) DEC. 12. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm. Schwabe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Schubacker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna Abendschoen

(Address) 2621 Guilford Ave

15 Filed AUG 31 1921 19 ROBERT P. PRUETT Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1921

17 I HEREBY CERTIFY, That I attended deceased from DEC 10th, 1919, to Aug. 29th, 1921, that I last saw her alive on Aug 28th 1921, and that death occurred, on the date stated above, at 4:10 A m.

The CAUSE OF DEATH* was as follows: Chr. Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of X

Was there an autopsy? X

What test confirmed diagnosis? X

(Signed) Edw Murray M. D.

(Address) 122 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Violetta Hill — DATE OF BURIAL 8-31 1921

20 UNDERTAKER Mrs Chas A Rohde — ADDRESS 1100 Linden Ave

N. B.—WRITE plainly and be carefully supplied. All information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 56559 (10-4-21) ✓ D 56559

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 S. Curley ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Hall

(a) RESIDENCE. NO. 1103 S. Curley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred – yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 6-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	–	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Armstrong R. Hall

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Katharine Graham

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Katharine Hall (Mother)
(Address) 1103 S. Curley St.

15 Filed AUG 31 1921 ROBERT I. KRAUTER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 30, 1921, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Ileo Colitis

2 mos. ds.
(duration) yrs.

CONTRIBUTORY (Secondary) Bronchio Pneumonia
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A B Sellers, M. D.

8/31, 1921 (Address) 315 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Patrick's Cemetery

DATE OF BURIAL Sept. 1 1921

20 UNDERTAKER Zickler + Zickler

ADDRESS 1739 E. Eager

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 52 D 56560

1-PLACE OF DEATH D 56560 Johns Hopkins Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. — St.: 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Barham

(a) RESIDENCE. No. — St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 8/24/21

7 AGE	Years	Months	Days →	If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Barham

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) Va.

12 MAIDEN NAME OF MOTHER Susie Turner

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Md.

14 Informant To Gamble Md
(Address) Johns Hopkins Hosp

15 Filed AUG 31 1921 Burial Permit Issued — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/25 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/24/, 1921, to 8/25/, 1921,

that I last saw him alive on 8/25/, 1921,

and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Birth injuries.

Intra Cranial Haemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY ✓
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) E. L. Stone, M. D.

8/26 1921 (Address) J. H. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS AUG 30 1921

JOHNS HOPKINS HOSPITAL

Commissioner Health.

MAKE CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. CAUSE OF DEATH is very important.

1846

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56561

CERTIFICATE OF DEATH.

8 ✓ 9 D 56561

REGISTERED NO.....

1-PLACE OF DEATH Nursery & Childs Hospital

CITY OF BALTIMORE: (No. Lanvale & Schroeder ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Colson

(a) RESIDENCE. NO. Nursery & Childs Hosp ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch - 1920?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child pt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co — Md.

PARENTS

10 NAME OF FATHER George Colson —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md — ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) [illegible]

15 Filed AUG 31 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 — 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1921, to Aug. 20, 1921, that I last saw him alive on Aug. 29 — 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Brad F. Kline M. D.

, 19 (Address) 1000 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	Aug 31 1921
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner Health.

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56562

CERTIFICATE OF DEATH. 182

D 56562

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~519 N. Exeter~~ Mercy Hospital 5 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Simms

(Residence in Baltimore: No. 519 N. Exeter St.; yrs., 23 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1 (Month) (Day) (Year)

7-AGE, 27 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Joseph Luckey

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Florence Lucky

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Compton

(Address) 619 Eutaw st

15- AUG 31 1921 191.. ROBERT J KRAUTER Undertaker. Burial Permit Issued. Resident.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... August 30, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in Chest,

1 hour (Duration) ..... yrs. 1 hour mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Kelly M. D.

(Coroner)

Aug 30 1921 (Address) 1089 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Laurel

DATE OF BURIAL, Sept 1 1921

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

N. B.—Every item of information should be carefully supplied, that the CAUSE OF DEATH may be properly classified. Exact information is important. See instructions on back of certificate.

D 56563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56563

CERTIFICATE OF DEATH.

5 1821

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5-19 N. Eden St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie Smoky

(Residence in Baltimore: No. 5-19 N. Eden St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Wid.

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 55 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country). Balto -

PARENTS.

10-NAME OF FATHER: Edward Burk

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER: Hariet Robinson

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dennis Cooper

(Address) 317 Eastern Ave

15- AUG 31 1921 ROBERT F KRAUTER

1921 191..... Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 30, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to. ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shot wound thorax
Kidney Chest & Stomach cavity
2 or 3 minutes (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Homicide
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Kelly M. D. (Coroner.)

Aug 30, 1921 (Address) 1 E & 7 Barnes

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, Sept 2, 1921

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56564

CERTIFICATE OF DEATH.

167

D 56564

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No..... Hebrew Hospital. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence E. Hiss.

(Residence in Baltimore: No. 2942 Clifton Ave. St.; 3 yrs., 10 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH, October 14th. 1917., 1
(Month) (Day) (Year)

7-AGE, 3 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Benjamin E. Hiss.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Sadie Warner.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin E. Hiss. (father)

(Address) 2942 Clifton Ave.

15- Robert P. Harrison,

Filed....., 191..... Registrar.

~~Burial Permit Clerk.~~

AUG 31 1921

N. B.—Every item of information should be carefully considered, that the CAUSE OF DEATH may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 29th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental burns about the face and body. Playing with matches.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Otto K. Pennard M. D.
(Coroner.)

Aug. 29., 191.21 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cem	9/1, 1921
20-UNDERTAKER	ADDRESS
I. Frew McCully	130 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56565

CERTIFICATE OF DEATH.

1201 D 56565

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Madison Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Duffy

(a) RESIDENCE. (No. 714 Madison Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred all life ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Carroll

6 DATE OF BIRTH (month, day, and year) Mar. 25, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel Stafford

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Michael Duffy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Farran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. Ella Carroll 714 Madison Avenue

15 Filed Robert P. Harrison, Registrar

AUG 31 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31, 1921.

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1921, to Aug 31, 1921, that I last saw him alive on Aug 30, 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Incompetency (duration) ds.

CONTRIBUTORY (secondary) Chronic Interstitial Nephritis (duration) 3 yrs 6 Mos

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) H. L. Huysen, M. D.

Aug 31, 1921 (Address) Wentworth Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	9/3, 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

mation should be carefully written in ink, and the certificate may be properly signed. CAUSE OF DEATH in plain terms, so that it may be correctly classified. Do not use abbreviations or symbols. Any additional information may be given on back of certificates. TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56566

D 56566

CERTIFICATE OF DEATH.

1 1 9 8 4 9

4 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florina Smith

(a) RESIDENCE. No. 219 Courtland St ST.,

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitoress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Austin Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Johns Hopkins Hospital Record

15 Filed AUG 31 1921

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1921

17

I HEREBY CERTIFY, That I attended deceased from June 8 1921. to Aug 30 1921.

that I last saw h[illegible] alive on Aug 30 1921.

and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

General Peritonitis (Purulent)
(Gall?) Intestinal Obstruction (Partial)

(duration) yrs. mos. 11 da.

CONTRIBUTORY (Secondary) Pyosalpinx (Chronic) Pelvic Inflammatory Disease

(duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 8/4/21

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H H Kerr M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Sept 2 1921
20 UNDERTAKER	ADDRESS
Felix B. Fox	102 Courtland St

mation should be entered.
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 56567 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56567

CERTIFICATE OF DEATH.

REGISTERED NO. 14966

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R Harsh

(a) RESIDENCE. NO. Milwaukee, Wis. ST., WARD. Milwaukee Wis

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Harsh.

6 DATE OF BIRTH (month, day, and year): Sept 9-1868

7 AGE: Years 50 Months 11 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manufacturers 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS

10 NAME OF FATHER: Wm Harsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: ? Rutherford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Johns Hopkins Hospital

15 Filed AUG 11 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31-1921

17 I HEREBY CERTIFY, That I attended deceased from July 25 , 1921, to Aug 31 , 1921, that I last saw him alive on Aug 31 , 1921, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): None -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 1) July 31 '21. 2) Aug 28 '21.

Was there an autopsy? Yes

What test confirmed diagnosis? Yes -

(Signed) Emil Holman M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Milwaukee Wis — DATE OF BURIAL: Aug 31 1921

20 UNDERTAKER: Henry Wenken & Sons — ADDRESS: Eschaet McCulloh St

mation should be carefully written in ink, and may be typewritten, so that it may be plainly legible. CAUSE OF DEATH in plain terms, so that it may be properly classified. See reverse side of certificates. TION is very important. See instructions on back.

(James C. Smith)

D 56568

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 56568

REGISTERED No. C

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1635 - Broadway ST. 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME James C. Smith

(Residence in Baltimore: No. ~~1635~~ 1635 - Broadway St.) (35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6. DATE OF BIRTH: Aug 12, 1841 (Month) (Day) (Year)

7. AGE: 80 yrs. mos. 15 ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): 016

9. BIRTHPLACE (State or country): Scotland

PARENTS

10. NAME OF FATHER: Nat Known.

11. BIRTHPLACE OF FATHER (State or country): Nat Known

12. MAIDEN NAME OF MOTHER: Nat Known

13. BIRTHPLACE OF MOTHER (State or country): Nat Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert H. Smith
(Address) 1635 E Broadway

15. Filed AUG 31 1921, 191 Robert P. Harrison, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 30, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1921, to Aug 30, 1921
that I saw h[illegible] alive on Aug 30, 1921
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

Dual Pneu (Duration) yrs. mos. ds.

Contributory (SECONDARY) Cerebral Hemorrhage (Duration) 4 yrs. mos. ds.

(Signed) [illegible] M. D.
Aug 30, 1921 (Address) 1635 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Sept 1, 1921

20. UNDERTAKER: E. J. Manning & Son

ADDRESS: 1911 W Lafayette Ave

N.B.-Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 56569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 MD 56569

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah F. Atkinson

(a) RESIDENCE. No. 609 N. Calhoun st. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1836 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER John H. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Margaret Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records (Address) M.T.H.

15 Filed AUG 31 1921, 19 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 19 21

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1919 to Aug. 30, 1921, that I last saw h er alive on Aug. 30, 1921, and that death occurred, on the date stated above, at 9.35 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic fibroid phthisis

(duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Francis L. Dalaglioglio M.D.

8-31-21. 19 (Address) Municipal Tb Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Robersonville NC	Aug. 31st 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Ballast

Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56570

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56570

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3402 Beech Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank X. Herrmann

(Residence in Baltimore: No. 3402 Beech Ave St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, September (Month) 29 (Day), 1861 (Year)

7-AGE, 59 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman in
(b) General nature of industry, business, or establishment in which employed (or employer): Factory

9-BIRTHPLACE, (State or Country) Balto Co Md

PARENTS.

10-NAME OF FATHER, Andreas Herrmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan E. Herrmann

(Address) 3402 Beech Ave

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

AUG 31 1921 Burial Permit Clerk.

N.B.—Every item of CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12 1921, to Aug 31 1921, that I saw him alive on Aug 31 1921, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Uraemic Coma from Chronic Interstitial Nephritis (Duration) 2 yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Duration) 5 yrs. ..... mos. ..... ds.

(Signed) A. Shelley M. D.

Aug 31, 1921 (Address) 3849 Kabundite

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Sept 3, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E Nord Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56571

CERTIFICATE OF DEATH.

64

D 56571

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1613 Lafayette Ave 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R Kraft

(a) RESIDENCE. No 1613 Lafayette Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3 1868

7 AGE: Years 53 Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John A Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eliza R Hollingshead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs Wallace C Kiser 717 N Payson St

15 Filed Aug 31 1921 Robert F. Harrison, Registrar

Burial Permit Cler[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1921, to Aug 29, 1921, that I last saw him alive on Aug 29, 1921, and that death occurred, on the date stated above, at 5.16 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Albert L Hesser M. D.

Aug 30, 1921 (Address) 1621 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park DATE OF BURIAL: Sept 2 1921

20 UNDERTAKER: J McCabe 502 E North Ave ADDRESS

AUG 31 1921

mation should be given in plain terms, so that it may be properly CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56572

CERTIFICATE OF DEATH.

D 56572

1-PLACE OF DEATH Franklin Square Hospital 108

CITY OF BALTIMORE: (No. F. S. H. ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Seward Jr.

(a) RESIDENCE. NO. 1472 Reynolds ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 17, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Freight handler

(b) General nature of industry, business, or establishment in which employed (or employer) R. R. 073

(c) Name of employer B & O

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Andrew J. Seward Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Carrie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Carrie H. Seward

(Address) 1472 Reynolds St

15 Filed 19 Robert F. Harrison, Registrar

G3 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 30, 1921, to Aug 31, 1921, that I last saw him alive on Aug 31, 1921, and that death occurred, on the date stated above, at 12.35 P m.

The CAUSE OF DEATH* was as follows:

Fulminating Appendicitis (Ruptured)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 31/21

Was there an autopsy? No

What test confirmed diagnosis? Clin findings

(Signed) Howard M. Bubert, M. D.

. 19 (Address) 1100 W. Eutaw F. S. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept 3 1921
20 UNDERTAKER William Cook	ADDRESS 5026 Nth

mation should be carefully answered, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56573

HEALTH DEPARTMENT—CITY OF BALTIMORE 1920

D 56573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital ST.: WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Master John Kahne

(a) RESIDENCE. NO. Walthorpe Md. WARD. Walthorpe Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 23/1909.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	12	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) School Boy

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard Kahne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Annie Farrer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr. Richard Kahne

(Address) Walthorpe Md.

15 Filed AUG 31 1921 19

Robert T. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1921, to Aug 30, 1921.

that I last saw him alive on Aug 30, 1921.

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows: OVER

Double Lobar Pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of 8-27-21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Dudley P. Bowe M. D.

19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem Lutheran Cemetery	Sept 2 1921
20 UNDERTAKER	ADDRESS
William Cook & Co.	502 E Nor

CAUSE OF DEATH to be filled in plain terms, and the certificate must be signed and dated on day of death. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Suspected osteomyelitis
Opened up the tibia
& found nothing.
Source of infection unknown.

Spec.--1-10-21--M&T--1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56574

D 56574

CERTIFICATE OF DEATH. × 186

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Jail

CITY OF BALTIMORE: (No. 10 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Alfred Brown

(a) RESIDENCE NO. ..... ST., ... WARD Texas

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 1026

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant City Jail Record

(Address)

15 Filed SEP 1 - 1921 19 ROBERT J KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1921, to —, 19..

that I last saw him alive on Sept 1, 1921,

and that death occurred, on the date stated above, at 7.50 m.

The CAUSE OF DEATH* was as follows:

Primary. Hanging

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dislocation vertebrae

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) William J Townsend, M. D.

19 (Address) 1113 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept 1 1921

20 UNDERTAKER Wm J Wise & Son Inc

ADDRESS 1935 N Paca St

N. B.—Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56575

CERTIFICATE OF DEATH.

145 D 56575

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2413 Mc Elderry St ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Edward Gesser

(a) RESIDENCE. NO. 2413 Mc Elderry St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos. 13 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edw Gesser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lillie Boss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Edward Gesser

(Address) 2413 Mc Elderry St

15 Filed . 19 ROBERT J. KRAFFT Registrar

SEP 1 - 1921 Burial Permit Issued

N. B.—[illegible] should be carefully answered, so that it may be proper[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18 1921 to Aug 31 1921

that I last saw him alive on Aug 31 1921

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Exfoliative Interitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. over ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Gesser M. D.

8/31 1921 (Address) 413 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Sept 1 1921
20 UNDERTAKER	ADDRESS
J Henrig & Co	2108 Eutaw

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Very definite diagnosis
No history of syphilis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56576

CERTIFICATE OF DEATH.

137 D 56576

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 Belgian Ave. WARD 27)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bertagy

(a) RESIDENCE. NO. 831 Belgian Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J Leo Bertagy

6 DATE OF BIRTH (month, day, and year) Nov 17 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29	9	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Solomon Silverman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J Leo Bertagy (Address) 831 Belgian ave

15 Filed SEP 1 - 1921, 19 ROBERT J KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1921, to Aug 29, 1921, that I last saw h[illegible] alive on Aug 29, 1921, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma Later

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of Sept 21/20.

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Chas B Feeney, M. D.

, 19 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 1st 1921

20 UNDERTAKER Wm C Miller ADDRESS 2334 Jefferson St

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 56577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56577

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 208 N Vincent a ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Fields

(Residence in Baltimore: No. 208 N Vincent St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, July (Month) 29 (Day), 1885 (Year)

7-AGE, 33 yrs. 1 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Steam R.R. Co.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Samuel Fields

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia

12-MAIDEN NAME OF MOTHER Elizabeth Snell

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Fields

(Address) 208 N Vincent

15- Filed SEP 1 1924, 191.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 1 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James W. Lawson (Coroner.) M. D.

Sept 1, 1924 (Address) 700 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Forest Hill — DATE OF BURIAL, Sept 3 1924

20-UNDERTAKER E Hawley — ADDRESS 115 E Mart St

N. B.—Every item of information should be given, so that it may be properly entered in the CAUSE OF DEATH in plain terms, so that it may be properly understood. It is important. See instructions on back of certificate.

Burial Permit Issued

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~56558~~ D 56578

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Presbyterian Home of Maryland St.) 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Agnes Reid

(Residence in Baltimore: No. 822 N. Carrollton ave. Presbyterian Home for Women & Md.) St.; 68 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, not known (Month) (Day) 1840 (Year)

7-AGE, 81 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Childs Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country), Ayrshire Scotland

PARENTS.

10-NAME OF FATHER, Thomas Reid

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Margaret not known

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgiana E. Gifford Supt

(Address) Presbyterian Home

15- SEP 1 - 1921 ROBERT J. KRAMER. Registrar.
Filed ..... By ..... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 31 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1919, to Aug. 31 - 1921, that I saw h[illegible] alive on Aug 30 - 1921, and that death occurred, on the date stated above, at 2. a. m.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis asthma & Senile Atrophy
Senility & Senility
(Duration) about 2 or 3 years mos. ds.
CONTRIBUTORY Extreme heat & Exhaustion
(Secondary) about 4 or 5 days
(Duration) yrs. mos. ds.
(Signed) Carlton M Cook M. D.
Aug 31 - 1921 (Address) 1127 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery
DATE OF BURIAL, Sept. 1, 1921
20-UNDERTAKER, Chas. G. Black
ADDRESS 742 W. North Ave

CAUSE OF DEATH in plain terms. Omissions important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56579

CERTIFICATE OF DEATH.

50 D 56579

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (Ward) 16 WARD)

2-FULL NAME Augustus S. Walker

(a) RESIDENCE. NO. 813 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia E. Walker

6 DATE OF BIRTH (month, day, and year) July 5 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lieutenant 0337

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore City Fire Dept

(c) Name of employer Eclipse Co

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) accomac co. Va

12 MAIDEN NAME OF MOTHER Lucinda Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

11 Informant Amelia E. Walker

(Address) 813 N. Gilmor st

15 SEP 1 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-30 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1921, to Aug 30, 1921, that I last saw him alive on Aug 30, 1921 and that death occurred, on the date stated above, at 11.50 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (secondary) Carbuncle Neck Cellulitis

Bronchopneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John O'Malley, M. D.

. 19 (Address) Maryland Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Sept 2 1921

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See back of certificates. TION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56580

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Bell Wolfkill

(Residence in Baltimore: No. Waynesboro Pa St.; ..... yrs., ... mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Feb (Month) 23 (Day), 1873 (Year)

7-AGE, 48 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Hall

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Susan McClain

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B C Wolfkill

(Address) Waynesboro Pa

15- SEP 1 - 1921 191.. ROBERT F KRAUTER Registrar. Burial Permit Issued.

CAUSE OF DEATH in plain terms. It is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1921, to Aug 31 1921, that I saw her alive on Aug 31 1921, and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Cholecystectomy

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) E E Duncan M. D.

Aug 31, 1921 (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Waynesboro Pa

19-PLACE OF BURIAL OR REMOVAL, Waynesboro Pa — DATE OF BURIAL, Sept 1, 1921

20-UNDERTAKER Chas. G. Black — ADDRESS 742 W North Ave

Body to Highfield and

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56581

CERTIFICATE OF DEATH.

64 56581

REGISTERED NO. 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

CITY OF BALTIMORE: No. 10 - Belvedere ave ST. 27 WARD)

2-FULL NAME Rebecca Ann. Grace

(a) RESIDENCE. No. 10 - Belvedere ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Grace

6 DATE OF BIRTH (month, day, and year) July 18 - 840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. md

PARENTS

10 NAME OF FATHER John Rector

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. md

12 MAIDEN NAME OF MOTHER Rebeca. Calhune

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. md.

14 Informant Harry Grace
(Address) 40-10 Belvedere ave
Arlington

15 Filed ....., 19... Registrar

SEP 1 - 1921

Burial

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1921, to Aug 30 1921, that I last saw h alive on Aug 30, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage
& Arteria Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas Smith M. D.

Aug 31. 1921 (Address) 4706 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cem. Towson	Sept 2 1921
20 UNDERTAKER	ADDRESS
John Burns Sons	Towson

MAKE ENTRIES in plain terms, so that every item may be understood. CAUSE OF DEATH in plain terms, so that every item may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56582 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 56582

CERTIFICATE OF DEATH.

391

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Franklin Square Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma C Hill

(a) RESIDENCE. No. 1022 W Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Hill

6 DATE OF BIRTH (month, day, and year) March 5, 1853.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Tarring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Kaufman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant (Address) John T. Hill 43 E. Williamson St

15 Filed SEP 1 - 1921 ROBERT J. BRAUNER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1921, to Aug 31, 1921, that I last saw her alive on Aug 31, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Sarcoma at angle of r jaw involving Glands of the neck

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes, Date of Aug 30, 21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. M. Finko, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept. 3, 1921

20 UNDERTAKER George J. Smith ADDRESS 1000 W Fayette St

mation should be given in answering these questions. CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56583 ✓ D 56583

CERTIFICATE OF DEATH.

79

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 W. North ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Alexie Valliant

(Residence in Baltimore: No. 610 W. north ave St.; 89 yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, June (Month) 9 (Day), 1832 (Year)

7-AGE, 89 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm Le Compte

11-BIRTHPLACE OF FATHER (State or Country), Cambridge Md

12-MAIDEN NAME OF MOTHER Mary Ann Lockerman

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. R. Valliant

(Address) 610 W. North Ave.

15-

Filed SEP 1 - 1921 ROBERT P. KRAFFT Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 1, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 1 1921, that I saw h alive on Sept 1 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) C. Lloyd Simmons M. D.

Sept 1, 1921 (Address) 4746 Liberty Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Royal Oaks Md. DATE OF BURIAL, Sept 2, 1921

20-UNDERTAKER George J. Smith ADDRESS Fayette

N.B.—Entries must be made in plain terms, so that it may be plain what is the CAUSE OF DEATH in plain terms, so that it may be plain what is the important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56584

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56584

152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 687 N. Mulberry St.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hockady

(a) RESIDENCE. NO. 687 N. Mulberry ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 2 ds. How long in U. S., if of foreign birth? ... yrs ... mos ... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	—	—	2	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Hockady

11 BIRTHPLACE OF FATHER (city or town) Littleton
(State or country) N. Carolina.

12 MAIDEN NAME OF MOTHER Bettie Neal

13 BIRTHPLACE OF MOTHER (city or town) Littleton
(State or country) N. Carolina.

14 Informant
(Address)

15 Sept 1 . 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

SEP 1 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1921, to Aug. 30, 1921, that I last saw him alive on Aug 30, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) L. J. Rigney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19
20 UNDERTAKER	ADDRESS

SEP 1 - 1921

JOHNS HOPKINS HOSPITAL

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56585 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56585

CERTIFICATE OF DEATH. 45

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hospt. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred. C. Haupt.

(a) RESIDENCE. NO. 3707 Springdale ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred (yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleonora B Haupt

6 DATE OF BIRTH (month, day, and year) Jan 7 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer M Clothing House

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizbeth Niemeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Eleonora Haupt 3707 Springdale Ave

15 Filed ..... 19..... Robert F. Harrison, Registrar

P 1 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1. 1921, to Aug. 31. 1921, that I last saw him alive on Aug 31 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Post operative Ileus

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Bladder.

(duration) ..... yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? yes Date of Aug. 25. 21.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Herbert C. Blake M. D.

. 19 (Address) 1014 W La Fayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 2 1921
20 UNDERTAKER Wm J Tracey Sons	ADDRESS North Ave

N. B.—WRITE [illegible] mation should be carefully supplied. Ages should be properly classified. Exact statements CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56586

CERTIFICATE OF DEATH.

43

D 56586

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 East 21st ST., 9 WARD)

2-FULL NAME Margaret W. Ford

(a) RESIDENCE NO. 712 East 21 St ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daughter of late C. W. and Henrietta Ford

6 DATE OF BIRTH (month, day, and year): Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
About	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: C. W. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cecil Co. Md

12 MAIDEN NAME OF MOTHER: ? Heins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co. Md

14 Informant: W. H. Ford

(Address): 500 W. Lanvale

15 Filed ....., 19..... Robert F. Harrison, Registrar

SEP 1 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31 1921

17 I HEREBY CERTIFY, That I attended deceased from January, 1921, to Aug. 31, 1921.

that I last saw him alive on Aug 30, 1921,

and that death occurred, on the date stated above, at 7:20 P m.

The CAUSE OF DEATH* was as follows:

Acute Carcinomatosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma Left Breast

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hains, M. D.

9-1-1921 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Sept 2 1921

20 UNDERTAKER: William Cook.

ADDRESS: Fay & North

It may be the property of ..... should be carefully ..... mation in plain terms, so that it may be ..... CAUSE OF DEATH ..... TION is very important. See instructions on back of certificates.

D 56587

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56587

168-001

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2246 Wilkins ave ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Smith

(Residence in Baltimore: No. 2246 Wilkins ave St.; yrs. 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	widower

6-DATE OF BIRTH, July (Month) 31, (Day) 1861 (Year)

7-AGE, 60 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. watchman
(b) General nature of industry, business, or establishment in which employed (or employer). B & O R R Co

9-BIRTHPLACE, (State or Country). Balto city

PARENTS.

10-NAME OF FATHER. George Smith

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Caroline Webb

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Smith

(Address) 2246 Wilkins ave

15-

Filed Sept 1/1921 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 31, (Day) 1921. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas Accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis

Myocarditis (Duration) yrs. 6 mos. ds.

(Signed) James W. Fulton M. D. (Coroner.)

191... (Address) Woodlawn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Sept. 3, 1921

20-UNDERTAKER C. W. Dill. ADDRESS 3109 Frederick Ave

N. B.—Every item of information should be given, so that it may be properly entered. CAUSE OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56588 ✓ D 56588

170

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO. 1907 Park Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millard Fillmore Burke (Resident)

(a) RESIDENCE. NO. 1907 Park Ave ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? 62 yrs. 7 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Cassel Burke

6 DATE OF BIRTH (month, day, and year) Jan-26-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Business

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Co

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Francis Burke

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Shaw

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs M. F. Burke (wife)

(Address) 1907 Park Ave

15 Filed Febr 19 Registrar

Burial Permit Clerk.

P 1 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1920 to Aug 31 1921, that I last saw him alive on Aug 30 1921, and that death occurred, on the date stated above, at 9.50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis & Hypostatic Congestion

OVER

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 20, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon N. Condon, M. D.

, 19 (Address) 750 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Sept 2 1921

20 UNDERTAKER STEWART & HOWSON COMPANY

ADDRESS 1118 N. NORTH AVE.

MAKE RETURN OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

D 56589

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

D 56589

REGISTERED NO. C

1 PLACE OF DEATH Hobbs

CITY OF BALTIMORE (No. 1323 N Fulton Ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Lida Hopkins Hobbs

(Residence in Baltimore: No. 1323 N. Fulton ave St.: 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~

4 COLOR OR RACE White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Sept 17, 1877
(Month) (Day) (Year)

7 AGE 48 yrs. 11 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None 037
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Prince George Co Md

PARENTS

10 NAME OF FATHER George W. Hopkins

11 BIRTHPLACE OF FATHER (State or country) Prince George Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Bowman

13 BIRTHPLACE OF MOTHER (State or country) Prince George Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary A Gates

(Address) Bowie Md

15 Robert F. Harrison,
Filed SEP 1 1921 Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 31, 1921
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 31 1921, that I saw her alive on Aug 30, 1921, and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) yrs. mos. 1 ds

Contributory (SECONDARY) Tuberculosis Intestine

(Duration) yrs. 6 mos. ds.

(Signed) W. Lazear M. D.

Aug 31, 1921 (Address) 1603 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Sept 2 1921

20 UNDERTAKER STEWART & POWER COMPANY

ADDRESS 1018 W. NORTH AVE.

B.-Every item of information should be carefully supplied. Exact statements are required by law. Do not use "unknown" or leave blank unless it may be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56590

D 56590

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 Jefferson ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. MARGARET A. HABIS,

(a) RESIDENCE. NO. 1519 Jefferson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 72 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Widow,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Habis,

6 DATE OF BIRTH (month, day, and year) Nov-11-1843.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work at home,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany,

PARENTS

10 NAME OF FATHER Serverin Becker,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Miss. M. Habis,

(Address) # 1519 Jefferson Street.

15 Filed Sept 1 1921 Robert P. Harrison, Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug 31 . 1921. to Sept 1 . 1921.

that I last saw h~ alive on Sept 1 . 1921.

and that death occurred, on the date stated above, at 2.30 A~ m.

The CAUSE OF DEATH* was as follows:

Apoplexy

2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Kerlin, M. D.

(Address) 62 N Bond, 1921.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery, DATE OF BURIAL Sept 3" 1921.

20 UNDERTAKER M. F. Sadowski, ADDRESS 705 S Ann St

EP 1 - 1921

Before writing, read carefully the directions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back. TION is very important.

Form.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56591

CERTIFICATE OF DEATH.

28

D 56591

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Odessa Nelson

(a) RESIDENCE. NO. 565 Orchard st. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chambermaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U.S.A.

PARENTS

10 NAME OF FATHER James Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Charlotte Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 SEP 2-1921 ROBERT J. KRAUTER Registrar Burial Permits Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27 1921, to Aug. 30 1921, that I last saw h or alive on Aug. 30 1921, and that death occurred, on the date stated above, at 10.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum.

(Signed) Francis J. Dabaghiaeu M. D.

8-31-21. 19 (Address) Municipal Tb Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 1-21
20 UNDERTAKER David Eastar	ADDRESS 916 Ba ml

REGISTRAR'S CERTIFICATE OF CAUSE OF DEATH in plain terms. If unknown, state that fact. See back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56592

CERTIFICATE OF DEATH.

164 D 56592

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 S. Charles St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy May Hughes

(a) RESIDENCE. No. 1714 S. Charles St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? 6 yrs. 3 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER David Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER Anna Lockman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant Mr. David Hughes
(Address) 1714 S. Cherles St.

15 Filed SEP 2-1921 ROBERT I. KRAUTH Registrar
Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30 . 19 21 to Ahg 31 . 1921 .
that I last saw her alive on Aug. 31 . 19 21
and that death occurred, on the date stated above, at 6.30 Am.
The CAUSE OF DEATH* was as follows:

Acute Acidosis (Chron)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ptomaine poisoning

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. F. Hawkins, M. D.

9/1 21 (Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	9,2, 1921
20 UNDERTAKER	ADDRESS
I. Few McCully	130 E. Fort Ave.

CAUSE OF DEATH in plain terms. Abbreviations on back of certificates. TION is very important. See instructions on back.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Eating Ice Cream and Watermelon

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56593

CERTIFICATE OF DEATH.

Immler ✓

37

REGISTERED NO.....

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (NO. 21 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Immler

(a) RESIDENCE. NO. 704 St Peter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? Fifty yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Minnie Immler

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Minnie Immler (Address) 704 St Peter St

15 Filed SEP 2 - 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1921, to Aug 31, 1921, that I last saw him alive on Aug. 30 1921, and that death occurred, on the date stated above, at 8.25 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (2 the Insane)

CONTRIBUTORY (Secondary) Lueticinfection (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Insane

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical Serological

(Signed) H. H. Smith M. D.

8/31/21 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Inc

DATE OF BURIAL Sept 2 1921

20 UNDERTAKER Colt Johnson

ADDRESS 1X4 2 21 03 Hay

mation should be given, so far as known. Use only full terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56594

CERTIFICATE OF DEATH.

15 | D 56594

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1649 Sth Fulton ST., 15 WARD)

2-FULL NAME Thomas F. Fox

(a) RESIDENCE NO. 1649 Sth Fulton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Colored boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER May Lloyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant May Fox
(Address) 1649 Sth Fulton Ave

15 SEP 2 - 1921 BOARD OF HEALTH Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1921, to Sept 1st, 1921, that I last saw h[illegible] alive on Sept 1st, 1921, and that death occurred, on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas Jones, M. D.

, 19 (Address) 2502 Rosslyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL Sept 2 1921

20 UNDERTAKER William Cook — ADDRESS 502 E Nott

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

D 56595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO. C

D 56595

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1731 Lamont St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Stafford

(Residence in Baltimore: No. 1731 Lamont St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH, Oct 2 (Month) (Day), 1720 (Year)

7-AGE, ... yrs. 11 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Patrick Stafford

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Hall

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Patrick Stafford

(Address) 1731 Lamont ave

15- Filed SEP 2 - 1921 191. ROBERT J. KRAUTER Registrar.

Burial Permit Issued

N. B.—Every item of DEATH in plain terms, so that it may be properly CAUSE OF DEATH important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Aug 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebro

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D. (Coroner.)

Sept 2, 1921, (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemty

DATE OF BURIAL, Sept 2, 19...

20-UNDERTAKER Siegel Ruth

ADDRESS 1735 Lamont ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56596

CERTIFICATE OF DEATH.

53 D 56596

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1825 W. North Ave (St.) 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William G. Seewald

(Residence in Baltimore: No. 1825 W. North Ave. St.: 57 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November 7th, 1864
(Month) (Day) (Year)

7-AGE. 57 yrs. 9 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Druggist
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. Philip Seewald

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Anna Preister

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Seewald

(Address) 1825 W. North Ave

15- SEP 2 - 1921 191.....

Filed ..... Burial Permit Issued ..... Registrar.

ROBERT J. KRAUTER

CAUSE OF DEATH. This information is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 1, 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1921, to Sept. 2 1921, that I saw him alive on Sept. 1 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Sepsis - Streptogenous Lymphadenitis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) K. C. Metzel M. D.

Sept. 2 1921. (Address) 1903 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. London Park — DATE OF BURIAL, Sep. 5th 1921

20-UNDERTAKER Martin Fahey, Sons — ADDRESS 827 W North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56597

D 56597

CERTIFICATE OF DEATH.

64

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 424 E 20th ST., 17 WARD)

2-FULL NAME Clara C. Nordorft

(a) RESIDENCE NO. 424 E 20th ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 29th 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Nordorft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Beisswenger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mrs Minnie Nordorft 424 E 20 th st

15 Filed SEP 2 - 1921 Burial Permit Given Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1921. to Aug. 31. 1921.

that I last saw her alive on " 31 1921,

and that death occurred, on the date stated above, at 6.20 a. m.

The CAUSE OF DEATH* was as follows:

Over

Septic Arthritis (duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Cerebral paralysis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A Hartmann M. D.

Aug. 31, 1921 (Address) 2214 Maryfield Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Sept 2nd 1921

20 UNDERTAKER George Schilling & Sons ADDRESS 126 E Monument st

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal cerebral hemorrhage

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 56598

D 56598

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth M Hammar

(a) RESIDENCE NO. 2119 Bolton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
fe	white	~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Morgan Hammar

6 DATE OF BIRTH (month, day, and year) Dec 24. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none. 00W

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Allen Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Alice Martin Gray.

(Address) 1210 W. Royal Avenue

15 Filed SEP 2 - 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1921, to Sept 1st, 1921, that I last saw h&r alive on Sept 1st, 1921, and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Elizabeth Arthurs, M. D.

, 19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Sept 3 1921

20 UNDERTAKER David McLean — ADDRESS 1018 Edmondson Av.

CAUSE OF DEATH in plain terms. Statement of contributory cause of death is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56599

CERTIFICATE OF DEATH.

43

REGISTERED NO. D 56599

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1818 E. North Ave. (Ward) 8

2-FULL NAME Amelia Willet

(a) RESIDENCE. No. 1818 E. North Ave St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced (HUSBAND of) (or WIFE of): Dora Willet

6 DATE OF BIRTH (month, day, and year): 12/4/1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hanover Penna

PARENTS

10 NAME OF FATHER: Edward Kopp Penna

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Sue Eactriden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn

14 Informant (Address): Dora Willet 1818 E North Ave

15 SEP 2 - 1921

16 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8 1921, to Aug 30 1921.

that I last saw h alive on Aug 30 1921.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 12 mos. ds

CONTRIBUTORY (Secondary): Hypostatic Pneumonia

(duration) yrs. mos. 6 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank N. Dilli, M. D.

, 19 (Address) 2438 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 9/2/21

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Harford

CAUSE OF DEATH in plain terms, so that it may be understood by the people. TION is very important. See instructions on back of certificates.

Spmc—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56600

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilson Talley

(a) RESIDENCE. NO. 2810 Simpson St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ? Talley

6 DATE OF BIRTH (month, day, and year) January, ?, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Wilson Talley

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mary Isen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant (Address) Johns Hopkins Hospital.

15 FILED SEP 2 1921 ROBERT I. KRAUTZ Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 1921 to Aug 30 1921.
That I last saw him alive on Aug 30 1921.
and that death occurred, on the date stated above, at 5:10 P m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis, Hypertensive, Cardiac Hypertrophy & Dilatation, Myocardial Insufficiency
(duration) yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical & Chemical tests
(Signed) George H. Gardner, M. D.
19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Sept 3rd 1921
20 UNDERTAKER	ADDRESS
Samuel Kennedy	778 W Baltimore

CAUSE OF DEATH in plain terms. ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56601

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 56601

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 560 Orchard ST., 17 WARD)

2-FULL NAME Jane Downs

(a) RESIDENCE NO. 560 Orchard ST., 17 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 870

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Robert Town Maryland

PARENTS

10 NAME OF FATHER Robert Swan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Swan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret Swan (Address) 560 Orchard St

15 Filed SEP 2 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1921 to Aug. 30, 1921

that I last saw her alive on Aug. 30, 1921

and that death occurred, on the date stated above, at 9:35 Pm.

The CAUSE OF DEATH* was as follows:

DW

Paralysis

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary)

Uremic Coma (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? XXXX

Did an operation precede death? No Date of XXX

Was there an autopsy? No

What test confirmed diagnosis? XXXX

(Signed) H. White, M. D.

19 (Address) 1118 Druid Hill Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Sept 1921

20 UNDERTAKER Samuel Townsley

ADDRESS 37 N Eutaw

CAUSE OF DEATH in plain terms. No abbreviations or initials. Do not use terms of duration only. INFORMATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably chr. nephritis. Terminal cerebral hemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56602

CERTIFICATE OF DEATH.

X 120 D 56602

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (NO. 1019 Peach Alley ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Robinson

(a) RESIDENCE. NO. 1019 Peach alley ST., 23 WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary E. Burgoff

(Address) 1019 Peach Alley

15 Filed SEP 2 - 1921 Burial Permit Issued by Registrar

CAUSE OF DEATH in part to be filled in by the attending physician or coroner. See reverse side of certificate. INFORMATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/23/ 1921, to 8/28/ 1921, that I last saw h. alive on 8/28/ 1921, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Subacute Interstitial nephritis (duration) about 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Gen Bowley, M. D.

8/31/ 1921 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Sept 2nd 1921

20 UNDERTAKER Samuel J. Kemmler ADDRESS 518 W Biddle

Spec.—6-9-19—H. P. Co.—1000 Bks.

Magaha.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56603

CERTIFICATE OF DEATH.

H0

D 56603

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1110 Ridgley, (St.:) 71 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. L. Magaha

(a) RESIDENCE. No. 1110 Ridgley St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Divorced

6 DATE OF BIRTH (month, day, and year) Jan 10 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police 061

(b) General nature of industry, business, or establishment in which employed (or employer) B & O Railroad

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Daniel Magaha

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Agnes Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. Jno. Cook

(Address) 1110 Ridgley St

15 Filed ..... 19.... Burial Permit Issued

SEP 2 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1921, to Aug 31, 1921, that I last saw him alive on Aug 29, 1921, and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) ....yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd. M. D.

Sept 1, 1921 (Address) 62 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 3 1921

20 UNDERTAKER John J. Fields ADDRESS 1200 W Fayette

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56604

D 56604

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 Burgundy ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Mc Cook

(a) RESIDENCE. NO. 1104 Burgundy ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Nelson Cooke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Annie Middleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Nelson Cooke

(Address) 1104 Burgundy Av

15 Filed SEP 2 - 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/2/21 19

17 I HEREBY CERTIFY, That I attended deceased from 8/30/, 1921, to 9/2/21, 19, that I last saw h e alive on 9/2/21, 19, and that death occurred, on the date stated above, at 7 1/4 p. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Philip Levy Drain M. D.

, 19 (Address) 1527 Calvert Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Sept 3 192

20 UNDERTAKER John Waldo ADDRESS 1200 W Fayette

CAUSE OF DEATH in plain terms. Do not use abbreviations or initials. Name of contagious disease must be given. Omission to state the cause of death as directed is punishable by a fine of not more than $100.00. See back of certificate. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56605

CERTIFICATE OF DEATH.

104 D 56605

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 602 So. Ann ST.: 7 nd. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CONSTINCE MALINOWSKI,

(a) RESIDENCE. No. 602 So. Ann ST., 2 nd. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Xxxx,

6 DATE OF BIRTH (month, day, and year) Nov-10.1920.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None, 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.,

PARENTS

10 NAME OF FATHER Stanislaus Malinowski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Mary Wroblewska, 84

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Mrs, Mary Malinowska, (Mother)
(Address) # 602 So. Ann Street

15 Filed SEP 2 - 1921 19 [illegible] Register

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1st 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 . 1921 . to Sept 1 . 1921.

that I last saw h... alive on Sept 1 . 1921.

and that death occurred, on the date stated above, at 6.15 A.- m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) #2 n Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.,	Sept 2" 1921
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	905 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56606

170 D 56606

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 280 S. Robinson ST., 1 WARD)

2-FULL NAME Mary Doyle

(a) RESIDENCE NO. 280 S. Robinson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, ~~widowed~~, or divorced (or) WIFE of Henry Doyle

6 DATE OF BIRTH (month, day, and year) Jan. 1853

7 AGE Years 68 Months Days If LESS than 1 day, ...hrs. or mitt.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Hugh Osborne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Jenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Nellie Doyle (Address) 280 S. Robinson

15 Filed ....., 19..... ~~ROBERT P. KRAUTER~~ Burial Permit Clerk

SEP 2 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 30 August 1921

17 I HEREBY CERTIFY, That I attended deceased from August 4, 1921, to August 30, 1921, that I last saw h[illegible] alive on August 30, 1921, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Uremia

Malignancy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Rheumatic Endocarditis (duration) 2 yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Gen. Phys. Examination

(Signed) A. E. McCausland M. D.

19 21 (Address) 3508 Gard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Bom

DATE OF BURIAL Sept 3 19 21

20 UNDERTAKER J. J. Moran

ADDRESS 30 E. Baltimore

mation should be given, so that it may be properly
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

D 56607 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 D 56607

CERTIFICATE OF DEATH. REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 536 E. 23rd St.) (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Owen Gorman

(Residence in Baltimore: No. 536 E. 23rd St.) 57 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, June (Month) 19 (Day), 1854 (Year)

7-AGE, 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country). Ireland.

PARENTS.

10-NAME OF FATHER, Owen Gorman

11-BIRTHPLACE OF FATHER (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Gorman

(Address) 536 E 23 St

15- SEP 2 - 1921 ROBERT J KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hunter Pinkney M. D.
(Coroner.)

Sept 3, 1921 (Address) City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral — DATE OF BURIAL, Sept 3, 1921

20-UNDERTAKER E A Wingfield — ADDRESS 501 E 22 St

N.B.—BEFORE FILLING IN CAUSE OF DEATH in plain terms, so that it may be understood, read carefully the important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 56608 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56608

CERTIFICATE OF DEATH.

8 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 E Oliver ST.; 8 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Lasky

(Residence in Baltimore: No. 1705 E Oliver St St.; ah 35 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE. White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH. January 15, 1861 (Month) (Day) (Year)

7-AGE. 60 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired Merch't
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE, (State or Country). Hungary

PARENTS.

10-NAME OF FATHER. Jonas Lasky

11-BIRTHPLACE OF FATHER (State or Country). Hungary

12-MAIDEN NAME OF MOTHER S. Mendelle

13-BIRTHPLACE OF MOTHER (State or Country). Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irma Lasky

(Address) 1705 E Oliver St

15-

Filed....., 191.....

SEP 2 - 1921

Registrar.

Burial Permit Clerk.

CAUSE OF DEATH must be given in all cases, and the certificate must be filled out in every particular. Omissions will cause delay, and may cause return of certificate for correction. Every question is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 1, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1921 to Sept 1 1921, that I saw h[illegible] alive on Sept 1 1921, and that death occurred, on the date stated above, at 3:35 m.

The CAUSE OF DEATH* was as follows: Aortic + mitral insuff

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John G. Schwerzmann M. D.

Sept 1 1921 (Address) 1120 W. Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baeto-Hebrew Cem.	Sept 6, 1921
20-UNDERTAKER	**ADDRESS**
Jack Evans 1411 E	Baeto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56609

170 D 56609

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 E. Lombard St. 3 WARD)

2-FULL NAME Chas. M. Brager

(a) RESIDENCE NO. 1622 E Lombard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 30 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor O&D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1411 E Baltimore

15 Filed SEP 2 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to Aug. 31, 1921, that I last saw h[illegible] alive on Aug. 31, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Arteria-Sclerosis, Hypertension, Chronic Interstitial nephritis

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R.A. Nicholson, M. D.

, 19 (Address) 1420 E. Oliver, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hospital — DATE OF BURIAL 9/2 1921

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56610 — 64 ✓ — D 56610

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 416 N Stricker ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles D Hahn

(Residence in Baltimore: No. 416 N. Stricker St.; Ufe.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, Sept. (Month) ..... (Day) 1860 (Year)

7-AGE,	If LESS than 1 day,
61 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer): Grocery Store

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Lawrence J Hahn

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Schafer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W Hahn

(Address) 137 N. Payson St.

15- SEP 2 - 1921 — ROBERT J. KRAUTH — Registrar

Filed ....., 191.....

Burial Permit Issued

CAUSE OF DEATH. This information is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 21 1921, to Sept 1 1921, that I saw h.. alive on Aug 31 1921, and that death occurred, on the date stated above, at 6.22 a.m.

The CAUSE OF DEATH* was as follows:

..... Cardiac Failure .....

..... (Duration) ..... yrs. ....., mos. 3 ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

9/2/21, 191... (Address) 1202 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Sept. 2.., 1921
20-UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette St

Apoplectic 7

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

Reahl

HEALTH DEPARTMENT—CITY OF BALTIMORE

50

D 56611

D 56611

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Bon Secours Hospital St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. G. Edward Reahle.

(Residence in Baltimore: No. 11 N. Monroe St. St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, June (Month) 4 (Day), 1870 (Year)

7-AGE. 51 yrs. 2 mos. 28 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coal Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): Coal

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Joseph Reahl

11-BIRTHPLACE OF FATHER (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER Anna Aurich

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Reahl (wife).

(Address) 11 N. Monroe St.

15- Filed SEP 2 - 1921, 191.... ROBERT J KRAUSE Clerk

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 - 7.50 PM 1921, to Sept 2 - 6.00 AM 1921, that I saw him alive on Sept 2. 1921, and that death occurred, on the date stated above, at 6.00 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.
Diabetic Gangrene
Diabetic Coma
(Duration) 7 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Dr Cancer Resident
(Duration) yrs. mos. ds.

(Signed) L. Lloyd Johnson M. D.

Sept 2, 1921. (Address) Bon Secours Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL. Sept. 5, 1921

20-UNDERTAKER S. P. Offutt, Sr.

ADDRESS 228 E. Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56612

CERTIFICATE OF DEATH.

64 D 56612

1-PLACE OF DEATH Cicel Apt

CITY OF BALTIMORE. (No. Entaw Near Dolphin St.; 11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margretta Grace B. Mc-Culloch

(a) RESIDENCE. No. Entaw Near Dolphin St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: about 75. (Years / Months / Days) If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N. J.

PARENTS

10 NAME OF FATHER Richard S. Mc-Culloch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant W. McCulloch Brown (Address) Oakland Md

15 Filed SEP 2 - 1921 ROBERT F. KRAMER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to Sept 1st, 1921, that I last saw h[illegible] alive on Aug 31st, 1921, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Arteria-Sclerosis / Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence only

(Signed) H. F. Lemmon, M. D.

, 19 (Address) 8 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Glencoe Md — DATE OF BURIAL: Sept 3rd 192[illegible]

20 UNDERTAKER: A. Watkins & Sons Co — ADDRESS: Edward McCulloch

CAUSE OF DEATH to plain [illegible] TION is very important. See instructions on back of certificate.

Spec.-1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

X43 ✓

D 56613

CERTIFICATE OF DEATH.

D 56613

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. John + Lafayette Sts ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Eliza S.B. Thomas

(a) RESIDENCE NO. 2012 Hanover Balto. Co. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Divorced

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William Wallace Thomas

6 DATE OF BIRTH (month, day, and year) Oct. 7 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	42	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

PARENTS

10 NAME OF FATHER James Hollis Buchanan

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country)

12 MAIDEN NAME OF MOTHER Henrietta Gittings

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Thos H. Buchanan
(Address) Rogers Md

15 Filed SEP 2 — 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11 I, 1921, to Sept 1st, 1921, that I last saw her alive on Sept 1st, 1921, and that death occurred, on the date stated above, at 3.42 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Spine. (metastatic.)

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) carcinoma of breast.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Dr Arthurs

(Signed) Elizabeth Arthurs, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Sept 3 1921

20 UNDERTAKER Henry A Jenkins & Son Co

ADDRESS Eastland Hamilton Md

Lic. U. 3166

CAUSE OF DEATH in plain terms, so that no other cause can be substituted. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56614 — 56614

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 E. 25th St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. Sweeney

(a) RESIDENCE. NO. 112 E. 25 th St. ST., WARD.

(Usual place of abode) Lifetime (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 170

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer McCormick & Co.

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John Sweeney,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. W. T. Harrington

(Address) 112 E. 25th St.

15 SEP 2-1921 ROBERT J. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept, 1st, 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to Aug. 31, 1921, that I last saw him alive on Aug. 31, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of the face.

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

9-1, 1921 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery.	9/3/21. 19

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 Lanvale Royal Ex

CAUSE OF DEATH in plain ... See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56615

CERTIFICATE OF DEATH.

50 8 8 9

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 W. Randall ST.: 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Robert Schmidt

(a) RESIDENCE. NO. 6 W. Randall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Olivia Schmidt

6 DATE OF BIRTH (month, day, and year) Aug 14 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Conductor

(h) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Christian Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Tackla

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Olivia Schmidt (Address) #6 W. Randall

15 Filed . 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10 1921 to Sept 1 1921

that I last saw h m alive on Aug 31 1921

and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) L

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Microscopic

(Signed) Addison Hoover, M. D.

Sept 4 1924 (Address) 4 E 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Bess	Sept 3 1924
20 UNDERTAKER	ADDRESS
Mrs J E Evans & Sons	1420 N Charles

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56616

D 56616

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thomas

(a) RESIDENCE. NO. 732 W. Saratoga St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama.

PARENTS

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Lydia Carion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed SEP 2 - 1921 [illegible] Registrar

CAUSE OF DEATH on back of certificates. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28 1921

17 I HEREBY CERTIFY, That I attended deceased from August 23. 1921, to August 28. 1921. that I last saw him alive on August 28. 1921. and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 6 mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde Mitchell, M. D.

8/28/ 1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER (Commissioner Health.

ADDRESS SEP 2 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56617

CERTIFICATE OF DEATH.

91 D 56617

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ~~16~~ 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Agell

(a) RESIDENCE. No. None ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Agell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed SEP 2 - 1921, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 29 19 21

17 I HEREBY CERTIFY, That I attended deceased from August 28, 19 21 to August 29, 19 21

that I last saw him alive on August 29, 19 21

and that death occurred, on the date stated above, at 9:45 P.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde O'Neill, M. D.

8/30/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS SEP 2 - 1921

CAUSE OF DEATH in plain terms, ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56618

D 56618 CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View; 96 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Foster

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Anne Arundal Co., Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed SEP 2 - 1921 ROBERT J. KRAUTH Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30 1921

17 I HEREBY CERTIFY, That I attended deceased from August 27, 1921, to August 30, 1921, that I last saw her alive on August 30, 1921, and that death occurred, on the date stated above, at 11:45 A.m.

The CAUSE OF DEATH* was as follows:

1. Bronchopneumonia (duration) ... mos. ... ds.

CONTRIBUTORY (Secondary) Hemiplegia (Cer. Hem.) (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

8/31/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL

20 UNDERTAKER Commissioner Health.

Asst. Wm. E. WOODALL

ADDRESS 1921 SEP 2

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of c... of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Bareham

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56619 D 56619

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH 3527 Cedar Ave. 13

CITY OF BALTIMORE: (No. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda Bareham.

(Residence in Baltimore: No. 3527 Cedar Ave; St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown, (Month) (Day) 1 (Year)

7-AGE, about 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Co. Md

PARENTS.

10-NAME OF FATHER, Emanuel Fisher

11-BIRTHPLACE OF FATHER (State or Country) Lancaster Co. Pa.

12-MAIDEN NAME OF MOTHER Susanna Roser.

13-BIRTHPLACE OF MOTHER (State or Country) Lancaster Co. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bareham

(Address) 3407 Chestnut Ave.

15- ROBERT J. KRAUTER

Filed SEP 2 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 1, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1920, to Sept 1921, that I saw h[illegible] alive on Sept 1 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Cerebral arteriosclerosis

Chronic Myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(Duration) yrs. mos. 2 ds.

(Signed) [illegible] M. D.

Sept. 2nd, 1921 (Address) 3429 Chestnut Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Freedom Pa. DATE OF BURIAL, Sept 5, 1921.

20-UNDERTAKER Walter R. McNamee ADDRESS 801 Wellington St

CAUSE OF DEATH. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

15 c 330
D 56620

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 56620

CERTIFICATE OF DEATH. X 69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: ? WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vera McCarthy

(a) RESIDENCE. NO. 13 W. G. St. ST.: Sparrows Point WARD. Md Sparrows Point
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12 1917.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Andrew McCarthy

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Virginia

12 MAIDEN NAME OF MOTHER Artie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed Sept 2 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 27 1921, to Sept. 1 1921, that I last saw her alive on Sept. 1 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Epilepsy (Status epilepticus)

age. 4 yrs 6 mo. 20 da.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? O Date of —

Was there an autopsy? no

What test confirmed diagnosis? ?

(Signed) Horace G. Stewart, M. D.

9. 2. 21, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fordwick Augusta Co. Va.	Sept 2 1921
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Eutaw

CAUSE OF DEATH in plain terms. Abbreviations and terms of classification not permitted. See instructions on back of certificates. TION is very important.

P 2-1921

Spec.—1-10-21—M&T—1500 Bks.

D 56621

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56621

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST., 24 WARD)

2-FULL NAME Roy L. Headen

(a) RESIDENCE NO. US. PHS Hosp. #56 Ft. McHenry ST Balto. MD WARD 39
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) ---

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
25 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Edgar T Rosenbrock. Registrar.
(Address) US PHS Hosp. #56 Baltimore

15 Filed ... 19 ... Robert F. Harrison, Registrar

1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1921, to Sept. 1, 1921, that I last saw him alive on Sept. 1, 1921, and that death occurred, on the date stated above, at 9'10 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far adv. active.

July 18,/21 (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ----- (duration) --- yrs. --- mos. --- ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam. & Clinic report

(Signed) Thomas B. Payne M. D.
Senior Surgeon (R)

9/1, 1921 (Address) US PHS Hosp. # 6 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chapel Hill. N C.

DATE OF BURIAL Sept 2, 1921

20 UNDERTAKER Sol Levinson

ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be understood. Do not use abbreviations or terms of doubtful meaning. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56622 D 56622

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 E Biddle ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F Dietrich

(a) RESIDENCE. NO. 1902 E Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29-1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Richard P Dietrich

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary E Murphy

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Richard P Dietrich
(Address) 1802 E Biddle

15 Filed Sept 2 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 1921, to Aug 31, 1921.

That I last saw him alive on Aug 31, 1921.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. F. Harrison, M. D.

Sept 1, 1921 (Address) 130 N Pat Rose

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pat Cemetery	Sept 3 1921
20 UNDERTAKER	ADDRESS
Robt J Turner	1462 N. Bway

CAUSE OF DEATH in plain terms, such as consumption, cancer, etc. Do not use words of doubtful meaning. Do not use abbreviations. Do not report mode of dying, such as heart failure, asthenia, etc. Do not report symptoms, such as pain, weakness, etc. Do not report duration of disease. Do not report conditions which did not cause death. Do not report contributory causes unless they are related to the cause of death. Do not report complications unless they are the cause of death. Do not report operations unless they are the cause of death. Do not report accidents unless they are the cause of death. Do not report injuries unless they are the cause of death. Do not report poisonings unless they are the cause of death. Do not report suicides unless they are the cause of death. Do not report homicides unless they are the cause of death. Do not report executions unless they are the cause of death. Do not report deaths from natural causes unless they are the cause of death. Do not report deaths from unknown causes unless they are the cause of death. Do not report deaths from undetermined causes unless they are the cause of death. Do not report deaths from multiple causes unless they are the cause of death. Do not report deaths from combined causes unless they are the cause of death. Do not report deaths from indirect causes unless they are the cause of death. Do not report deaths from direct causes unless they are the cause of death. Do not report deaths from primary causes unless they are the cause of death. Do not report deaths from secondary causes unless they are the cause of death. Do not report deaths from tertiary causes unless they are the cause of death. Do not report deaths from quaternary causes unless they are the cause of death. Do not report deaths from quinary causes unless they are the cause of death. Do not report deaths from senary causes unless they are the cause of death. Do not report deaths from septenary causes unless they are the cause of death. Do not report deaths from octonary causes unless they are the cause of death. Do not report deaths from nonary causes unless they are the cause of death. Do not report deaths from denary causes unless they are the cause of death. Do not report deaths from undenary causes unless they are the cause of death. Do not report deaths from duodenary causes unless they are the cause of death. Do not report deaths from tredenary causes unless they are the cause of death. Do not report deaths from quattuordenary causes unless they are the cause of death. Do not report deaths from quindenary causes unless they are the cause of death. Do not report deaths from sexdenary causes unless they are the cause of death. Do not report deaths from septendenary causes unless they are the cause of death. Do not report deaths from octodenary causes unless they are the cause of death. Do not report deaths from novendenary causes unless they are the cause of death. Do not report deaths from vigenary causes unless they are the cause of death. Do not report deaths from unvigenary causes unless they are the cause of death. Do not report deaths from duovigenary causes unless they are the cause of death. Do not report deaths from trevigenary causes unless they are the cause of death. Do not report deaths from quattuorvigenary causes unless they are the cause of death. Do not report deaths from quinvigenary causes unless they are the cause of death. Do not report deaths from sexvigenary causes unless they are the cause of death. Do not report deaths from septenvigenary causes unless they are the cause of death. Do not report deaths from octovigenary causes unless they are the cause of death. Do not report deaths from novenvigenary causes unless they are the cause of death. Do not report deaths from trigenary causes unless they are the cause of death. Do not report deaths from untrigenary causes unless they are the cause of death. Do not report deaths from duotrigenary causes unless they are the cause of death. Do not report deaths from tretrigenary causes unless they are the cause of death. Do not report deaths from quattuortrigenary causes unless they are the cause of death. Do not report deaths from quintrigenary causes unless they are the cause of death. Do not report deaths from sextrigenary causes unless they are the cause of death. Do not report deaths from septentrigenary causes unless they are the cause of death. Do not report deaths from octotrigenary causes unless they are the cause of death. Do not report deaths from noventrigenary causes unless they are the cause of death. Do not report deaths from quadragenary causes unless they are the cause of death. Do not report deaths from unquadragenary causes unless they are the cause of death. Do not report deaths from duoquadragenary causes unless they are the cause of death. Do not report deaths from trequadragenary causes unless they are the cause of death. Do not report deaths from quattuorquadragenary causes unless they are the cause of death. Do not report deaths from quinquadragenary causes unless they are the cause of death. Do not report deaths from sexquadragenary causes unless they are the cause of death. Do not report deaths from septenquadragenary causes unless they are the cause of death. Do not report deaths from octoquadragenary causes unless they are the cause of death. Do not report deaths from novenquadragenary causes unless they are the cause of death. Do not report deaths from quinquagenary causes unless they are the cause of death. Do not report deaths from unquinquagenary causes unless they are the cause of death. Do not report deaths from duoquinquagenary causes unless they are the cause of death. Do not report deaths from trequinquagenary causes unless they are the cause of death. Do not report deaths from quattuorquinquagenary causes unless they are the cause of death. Do not report deaths from quinquinquagenary causes unless they are the cause of death. Do not report deaths from sexquinquagenary causes unless they are the cause of death. Do not report deaths from septenquinquagenary causes unless they are the cause of death. Do not report deaths from octoquinquagenary causes unless they are the cause of death. Do not report deaths from novenquinquagenary causes unless they are the cause of death. Do not report deaths from sexagenary causes unless they are the cause of death. Do not report deaths from unsexagenary causes unless they are the cause of death. Do not report deaths from duosexagenary causes unless they are the cause of death. Do not report deaths from tresexagenary causes unless they are the cause of death. Do not report deaths from quattuorsexagenary causes unless they are the cause of death. Do not report deaths from quinsexagenary causes unless they are the cause of death. Do not report deaths from sexsexagenary causes unless they are the cause of death. Do not report deaths from septensexagenary causes unless they are the cause of death. Do not report deaths from octosexagenary causes unless they are the cause of death. Do not report deaths from novensexagenary causes unless they are the cause of death. Do not report deaths from septuagenary causes unless they are the cause of death. Do not report deaths from unseptuagenary causes unless they are the cause of death. Do not report deaths from duoseptuagenary causes unless they are the cause of death. Do not report deaths from treseptuagenary causes unless they are the cause of death. Do not report deaths from quattuorseptuagenary causes unless they are the cause of death. Do not report deaths from quinseptuagenary causes unless they are the cause of death. Do not report deaths from sexseptuagenary causes unless they are the cause of death. Do not report deaths from septenseptuagenary causes unless they are the cause of death. Do not report deaths from octoseptuagenary causes unless they are the cause of death. Do not report deaths from novenseptuagenary causes unless they are the cause of death. Do not report deaths from octogenary causes unless they are the cause of death. Do not report deaths from unoctogenary causes unless they are the cause of death. Do not report deaths from duooctogenary causes unless they are the cause of death. Do not report deaths from treoctogenary causes unless they are the cause of death. Do not report deaths from quattuoroctogenary causes unless they are the cause of death. Do not report deaths from quinoctogenary causes unless they are the cause of death. Do not report deaths from sexoctogenary causes unless they are the cause of death. Do not report deaths from septenoctogenary causes unless they are the cause of death. Do not report deaths from octooctogenary causes unless they are the cause of death. Do not report deaths from novenoctogenary causes unless they are the cause of death. Do not report deaths from novagenary causes unless they are the cause of death. Do not report deaths from unnovagenary causes unless they are the cause of death. Do not report deaths from duonovagenary causes unless they are the cause of death. Do not report deaths from trenovagenary causes unless they are the cause of death. Do not report deaths from quattuornovagenary causes unless they are the cause of death. Do not report deaths from quinnovagenary causes unless they are the cause of death. Do not report deaths from sexnovagenary causes unless they are the cause of death. Do not report deaths from septennovagenary causes unless they are the cause of death. Do not report deaths from octonovagenary causes unless they are the cause of death. Do not report deaths from novennovagenary causes unless they are the cause of death. Do not report deaths from centenary causes unless they are the cause of death. Do not report deaths from uncentenary causes unless they are the cause of death. Do not report deaths from duocentenary causes unless they are the cause of death. Do not report deaths from trecentenary causes unless they are the cause of death. Do not report deaths from quattuorcentenary causes unless they are the cause of death. Do not report deaths from quincentenary causes unless they are the cause of death. Do not report deaths from sexcentenary causes unless they are the cause of death. Do not report deaths from septencentenary causes unless they are the cause of death. Do not report deaths from octocentenary causes unless they are the cause of death. Do not report deaths from novencentenary causes unless they are the cause of death. Do not report deaths from millenary causes unless they are the cause of death. Do not report deaths from unmillenary causes unless they are the cause of death. Do not report deaths from duomillenary causes unless they are the cause of death. Do not report deaths from tremillenary causes unless they are the cause of death. Do not report deaths from quattuormillenary causes unless they are the cause of death. Do not report deaths from quinmillenary causes unless they are the cause of death. Do not report deaths from sexmillenary causes unless they are the cause of death. Do not report deaths from septenmillenary causes unless they are the cause of death. Do not report deaths from octomillenary causes unless they are the cause of death. Do not report deaths from novenmillenary causes unless they are the cause of death. Do not report deaths from decamillenary causes unless they are the cause of death. Do not report deaths from undecamillenary causes unless they are the cause of death. Do not report deaths from duodecamillenary causes unless they are the cause of death. Do not report deaths from tredecamillenary causes unless they are the cause of death. Do not report deaths from quattuordecamillenary causes unless they are the cause of death. Do not report deaths from quindecamillenary causes unless they are the cause of death. Do not report deaths from sexdecamillenary causes unless they are the cause of death. Do not report deaths from septendecamillenary causes unless they are the cause of death. Do not report deaths from octodecamillenary causes unless they are the cause of death. Do not report deaths from novendecamillenary causes unless they are the cause of death. Do not report deaths from vigenamillenary causes unless they are the cause of death. Do not report deaths from unvigenamillenary causes unless they are the cause of death. Do not report deaths from duovigenamillenary causes unless they are the cause of death. Do not report deaths from trevigenamillenary causes unless they are the cause of death. Do not report deaths from quattuorvigenamillenary causes unless they are the cause of death. Do not report deaths from quinvigenamillenary causes unless they are the cause of death. Do not report deaths from sexvigenamillenary causes unless they are the cause of death. Do not report deaths from septenvigenamillenary causes unless they are the cause of death. Do not report deaths from octovigenamillenary causes unless they are the cause of death. Do not report deaths from novenvigenamillenary causes unless they are the cause of death. Do not report deaths from trigenamillenary causes unless they are the cause of death. Do not report deaths from untrigenamillenary causes unless they are the cause of death. Do not report deaths from duotrigenamillenary causes unless they are the cause of death. Do not report deaths from tretrigenamillenary causes unless they are the cause of death. Do not report deaths from quattuortrigenamillenary causes unless they are the cause of death. Do not report deaths from quintrigenamillenary causes unless they are the cause of death. Do not report deaths from sextrigenamillenary causes unless they are the cause of death. Do not report deaths from septentrigenamillenary causes unless they are the cause of death. Do not report deaths from octotrigenamillenary causes unless they are the cause of death. Do not report deaths from noventrigenamillenary causes unless they are the cause of death. Do not report deaths from quadragenamillenary causes unless they are the cause of death. Do not report deaths from unquadragenamillenary causes unless they are the cause of death. Do not report deaths from duoquadragenamillenary causes unless they are the cause of death. Do not report deaths from trequadragenamillenary causes unless they are the cause of death. Do not report deaths from quattuorquadragenamillenary causes unless they are the cause of death. Do not report deaths from quinquadragenamillenary causes unless they are the cause of death. Do not report deaths from sexquadragenamillenary causes unless they are the cause of death. Do not report deaths from septenquadragenamillenary causes unless they are the cause of death. Do not report deaths from octoquadragenamillenary causes unless they are the cause of death. Do not report deaths from novenquadragenamillenary causes unless they are the cause of death. Do not report deaths from quinquagenamillenary causes unless they are the cause of death. Do not report deaths from unquinquagenamillenary causes unless they are the cause of death. Do not report deaths from duoquinquagenamillenary causes unless they are the cause of death. Do not report deaths from trequinquagenamillenary causes unless they are the cause of death. Do not report deaths from quattuorquinquagenamillenary causes unless they are the cause of death. Do not report deaths from quinquinquagenamillenary causes unless they are the cause of death. Do not report deaths from sexquinquagenamillenary causes unless they are the cause of death. Do not report deaths from septenquinquagenamillenary causes unless they are the cause of death. Do not report deaths from octoquinquagenamillenary causes unless they are the cause of death. Do not report deaths from novenquinquagenamillenary causes unless they are the cause of death. Do not report deaths from sexagenamillenary causes unless they are the cause of death. Do not report deaths from unsexagenamillenary causes unless they are the cause of death. Do not report deaths from duosexagenamillenary causes unless they are the cause of death. Do not report deaths from tresexagenamillenary causes unless they are the cause of death. Do not report deaths from quattuorsexagenamillenary causes unless they are the cause of death. Do not report deaths from quinsexagenamillenary causes unless they are the cause of death. Do not report deaths from sexsexagenamillenary causes unless they are the cause of death. Do not report deaths from septensexagenamillenary causes unless they are the cause of death. Do not report deaths from octosexagenamillenary causes unless they are the cause of death. Do not report deaths from novensexagenamillenary causes unless they are the cause of death. Do not report deaths from septuagenamillenary causes unless they are the cause of death. Do not report deaths from unseptuagenamillenary causes unless they are the cause of death. Do not report deaths from duoseptuagenamillenary causes unless they are the cause of death. Do not report deaths from treseptuagenamillenary causes unless they are the cause of death. Do not report deaths from quattuorseptuagenamillenary causes unless they are the cause of death. Do not report deaths from quinseptuagenamillenary causes unless they are the cause of death. Do not report deaths from sexseptuagenamillenary causes unless they are the cause of death. Do not report deaths from septenseptuagenamillenary causes unless they are the cause of death. Do not report deaths from octoseptuagenamillenary causes unless they are the cause of death. Do not report deaths from novenseptuagenamillenary causes unless they are the cause of death. Do not report deaths from octogenamillenary causes unless they are the cause of death. Do not report deaths from unoctogenamillenary causes unless they are the cause of death. Do not report deaths from duooctogenamillenary causes unless they are the cause of death. Do not report deaths from treoctogenamillenary causes unless they are the cause of death. Do not report deaths from quattuoroctogenamillenary causes unless they are the cause of death. Do not report deaths from quinoctogenamillenary causes unless they are the cause of death. Do not report deaths from sexoctogenamillenary causes unless they are the cause of death. Do not report deaths from septenoctogenamillenary causes unless they are the cause of death. Do not report deaths from octooctogenamillenary causes unless they are the cause of death. Do not report deaths from novenoctogenamillenary causes unless they are the cause of death. Do not report deaths from novagenamillenary causes unless they are the cause of death. Do not report deaths from unnovagenamillenary causes unless they are the cause of death. Do not report deaths from duonovagenamillenary causes unless they are the cause of death. Do not report deaths from trenovagenamillenary causes unless they are the cause of death. Do not report deaths from quattuornovagenamillenary causes unless they are the cause of death. Do not report deaths from quinnovagenamillenary causes unless they are the cause of death. Do not report deaths from sexnovagenamillenary causes unless they are the cause of death. Do not report deaths from septennovagenamillenary causes unless they are the cause of death. Do not report deaths from octonovagenamillenary causes unless they are the cause of death. Do not report deaths from novennovagenamillenary causes unless they are the cause of death. Do not report deaths from centenamillenary causes unless they are the cause of death. Do not report deaths from uncentenamillenary causes unless they are the cause of death. Do not report deaths from duocentenamillenary causes unless they are the cause of death. Do not report deaths from trecentenamillenary causes unless they are the cause of death. Do not report deaths from quattuorcentenamillenary causes unless they are the cause of death. Do not report deaths from quincentenamillenary causes unless they are the cause of death. Do not report deaths from sexcentenamillenary causes unless they are the cause of death. Do not report deaths from septencentenamillenary causes unless they are the cause of death. Do not report deaths from octocentenamillenary causes unless they are the cause of death. Do not report deaths from novencentenamillenary causes unless they are the cause of death. Do not report deaths from millenamillenary causes unless they are the cause of death. Do not report deaths from unmillenamillenary causes unless they are the cause of death. Do not report deaths from duomillenamillenary causes unless they are the cause of death. Do not report deaths from tremillenamillenary causes unless they are the cause of death. Do not report deaths from quattuormillenamillenary causes unless they are the cause of death. Do not report deaths from quinmillenamillenary causes unless they are the cause of death. Do not report deaths from sexmillenamillenary causes unless they are the cause of death. Do not report deaths from septenmillenamillenary causes unless they are the cause of death. Do not report deaths from octomillenamillenary causes unless they are the cause of death. Do not report deaths from novenmillenamillenary causes unless they are the cause of death. Do not report deaths from decamillenamillenary causes unless they are the cause of death. Do not report deaths from undecamillenamillenary causes unless they are the cause of death. Do not report deaths from duodecamillenamillenary causes unless they are the cause of death. Do not report deaths from tredecamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuordecamillenamillenary causes unless they are the cause of death. Do not report deaths from quindecamillenamillenary causes unless they are the cause of death. Do not report deaths from sexdecamillenamillenary causes unless they are the cause of death. Do not report deaths from septendecamillenamillenary causes unless they are the cause of death. Do not report deaths from octodecamillenamillenary causes unless they are the cause of death. Do not report deaths from novendecamillenamillenary causes unless they are the cause of death. Do not report deaths from vigenamillenamillenary causes unless they are the cause of death. Do not report deaths from unvigenamillenamillenary causes unless they are the cause of death. Do not report deaths from duovigenamillenamillenary causes unless they are the cause of death. Do not report deaths from trevigenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorvigenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinvigenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexvigenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenvigenamillenamillenary causes unless they are the cause of death. Do not report deaths from octovigenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenvigenamillenamillenary causes unless they are the cause of death. Do not report deaths from trigenamillenamillenary causes unless they are the cause of death. Do not report deaths from untrigenamillenamillenary causes unless they are the cause of death. Do not report deaths from duotrigenamillenamillenary causes unless they are the cause of death. Do not report deaths from tretrigenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuortrigenamillenamillenary causes unless they are the cause of death. Do not report deaths from quintrigenamillenamillenary causes unless they are the cause of death. Do not report deaths from sextrigenamillenamillenary causes unless they are the cause of death. Do not report deaths from septentrigenamillenamillenary causes unless they are the cause of death. Do not report deaths from octotrigenamillenamillenary causes unless they are the cause of death. Do not report deaths from noventrigenamillenamillenary causes unless they are the cause of death. Do not report deaths from quadragenamillenamillenary causes unless they are the cause of death. Do not report deaths from unquadragenamillenamillenary causes unless they are the cause of death. Do not report deaths from duoquadragenamillenamillenary causes unless they are the cause of death. Do not report deaths from trequadragenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorquadragenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinquadragenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexquadragenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenquadragenamillenamillenary causes unless they are the cause of death. Do not report deaths from octoquadragenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenquadragenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinquagenamillenamillenary causes unless they are the cause of death. Do not report deaths from unquinquagenamillenamillenary causes unless they are the cause of death. Do not report deaths from duoquinquagenamillenamillenary causes unless they are the cause of death. Do not report deaths from trequinquagenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorquinquagenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinquinquagenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexquinquagenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenquinquagenamillenamillenary causes unless they are the cause of death. Do not report deaths from octoquinquagenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenquinquagenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexagenamillenamillenary causes unless they are the cause of death. Do not report deaths from unsexagenamillenamillenary causes unless they are the cause of death. Do not report deaths from duosexagenamillenamillenary causes unless they are the cause of death. Do not report deaths from tresexagenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorsexagenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinsexagenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexsexagenamillenamillenary causes unless they are the cause of death. Do not report deaths from septensexagenamillenamillenary causes unless they are the cause of death. Do not report deaths from octosexagenamillenamillenary causes unless they are the cause of death. Do not report deaths from novensexagenamillenamillenary causes unless they are the cause of death. Do not report deaths from septuagenamillenamillenary causes unless they are the cause of death. Do not report deaths from unseptuagenamillenamillenary causes unless they are the cause of death. Do not report deaths from duoseptuagenamillenamillenary causes unless they are the cause of death. Do not report deaths from treseptuagenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorseptuagenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinseptuagenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexseptuagenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenseptuagenamillenamillenary causes unless they are the cause of death. Do not report deaths from octoseptuagenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenseptuagenamillenamillenary causes unless they are the cause of death. Do not report deaths from octogenamillenamillenary causes unless they are the cause of death. Do not report deaths from unoctogenamillenamillenary causes unless they are the cause of death. Do not report deaths from duooctogenamillenamillenary causes unless they are the cause of death. Do not report deaths from treoctogenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuoroctogenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinoctogenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexoctogenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenoctogenamillenamillenary causes unless they are the cause of death. Do not report deaths from octooctogenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenoctogenamillenamillenary causes unless they are the cause of death. Do not report deaths from novagenamillenamillenary causes unless they are the cause of death. Do not report deaths from unnovagenamillenamillenary causes unless they are the cause of death. Do not report deaths from duonovagenamillenamillenary causes unless they are the cause of death. Do not report deaths from trenovagenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuornovagenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinnovagenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexnovagenamillenamillenary causes unless they are the cause of death. Do not report deaths from septennovagenamillenamillenary causes unless they are the cause of death. Do not report deaths from octonovagenamillenamillenary causes unless they are the cause of death. Do not report deaths from novennovagenamillenamillenary causes unless they are the cause of death. Do not report deaths from centenamillenamillenary causes unless they are the cause of death. Do not report deaths from uncentenamillenamillenary causes unless they are the cause of death. Do not report deaths from duocentenamillenamillenary causes unless they are the cause of death. Do not report deaths from trecentenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorcentenamillenamillenary causes unless they are the cause of death. Do not report deaths from quincentenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexcentenamillenamillenary causes unless they are the cause of death. Do not report deaths from septencentenamillenamillenary causes unless they are the cause of death. Do not report deaths from octocentenamillenamillenary causes unless they are the cause of death. Do not report deaths from novencentenamillenamillenary causes unless they are the cause of death. Do not report deaths from millenamillenamillenary causes unless they are the cause of death. Do not report deaths from unmillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duomillenamillenamillenary causes unless they are the cause of death. Do not report deaths from tremillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuormillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinmillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexmillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenmillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octomillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenmillenamillenamillenary causes unless they are the cause of death. Do not report deaths from decamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from undecamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duodecamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from tredecamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuordecamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quindecamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexdecamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septendecamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octodecamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novendecamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from vigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from unvigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duovigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from trevigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorvigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinvigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexvigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenvigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octovigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenvigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from trigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from untrigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duotrigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from tretrigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuortrigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quintrigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sextrigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septentrigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octotrigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from noventrigenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quadragenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from unquadragenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duoquadragenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from trequadragenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorquadragenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinquadragenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexquadragenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenquadragenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octoquadragenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenquadragenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinquagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from unquinquagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duoquinquagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from trequinquagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorquinquagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinquinquagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexquinquagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenquinquagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octoquinquagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenquinquagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from unsexagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duosexagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from tresexagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorsexagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinsexagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexsexagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septensexagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octosexagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novensexagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septuagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from unseptuagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duoseptuagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from treseptuagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorseptuagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinseptuagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexseptuagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenseptuagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octoseptuagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenseptuagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octogenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from unoctogenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duooctogenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from treoctogenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuoroctogenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinoctogenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexoctogenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenoctogenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octooctogenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenoctogenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from unnovagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duonovagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from trenovagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuornovagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinnovagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexnovagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septennovagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octonovagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novennovagenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from centenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from uncentenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duocentenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from trecentenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorcentenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quincentenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexcentenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septencentenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octocentenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novencentenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from millenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from unmillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duomillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from tremillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuormillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quinmillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexmillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septenmillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octomillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novenmillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from decamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from undecamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duodecamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from tredecamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuordecamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quindecamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from sexdecamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from septendecamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from octodecamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from novendecamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from vigenamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from unvigenamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from duovigenamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from trevigenamillenamillenamillenamillenary causes unless they are the cause of death. Do not report deaths from quattuorvigenamillenamillenamillenamillenary causes unless they are the cause of death. Do not

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56623 D 56623

CERTIFICATE OF DEATH.

109 REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 Bevans St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Roberts

(Residence in Baltimore: No. 1203 Bevans St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ✓ (Month) ..... (Day) 1851 (Year)

7-AGE, 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic 037
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unk

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Roberts

(Address) 1203 Bevans St

15- Robert P. Harrison,

Aug 30 1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug. 30th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8/28/21, to 8/30th 1921, that I saw h— alive on 8/30/1921, and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Hemorrhage Cerebral

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Following Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

Dr. Aug 27th 1921 Dr. Chas Smith M. D.

(Signed) .....

9/1, 1921 (Address) 5 E. 4th Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, W. M. Cemetery

DATE OF BURIAL, Sept 2, 1921.

20-UNDERTAKER Edwin Hendley

ADDRESS Madison

CAUSE OF DEATH must be stated plainly and accurately. Use no abbreviations. Do not state mode of dying, but the disease or injury which caused death. Indefinite terms, such as "Debility," "Old Age," "Paralysis," "Convulsions," "Cancer," "Tumor," "Abscess," "Child-bed," "Fever," "Inflammation," "Consumption," "Dropsy," "Heart Disease," "Kidney Disease," "Liver Disease," "Lung Disease," "Stomach Trouble," "Bowel Trouble," "Womb Trouble," "Rheumatism," "Erysipelas," "Blood Poisoning," "Gangrene," "Spinal Disease," "Brain Disease," "Meningitis," "Hernia," "Ulcer," "Tetanus," "Jaundice," "Hemorrhage," "Locomotor Ataxia," "Epilepsy," "Hydrocephalus," "Scrofula," "Scarlatina," "Measles," "Whooping Cough," "Diphtheria," "Typhoid Fever," "Malarial Fever," "Pneumonia," "Bronchitis," "Pleurisy," "Peritonitis," "Cholera Infantum," "Cholera Morbus," "Diarrhoea," "Dysentery," "Colitis," "Enteritis," "Gastritis," "Gastro-Enteritis," "Gastro-Intestinal Catarrh," "Entero-Colitis," "Ileo-Colitis," "Cystitis," "Nephritis," "Uremia," "Puerperal Convulsions," "Puerperal Septicemia," "Puerperal Peritonitis," "Puerperal Fever," "Phlegmasia Dolens," "Milk Leg," "Childbirth," "Abortion," "Miscarriage," "Premature Birth," "Stillborn," "Congenital Debility," "Congenital Malformation," "Congenital Hydrocephalus," "Congenital Syphilis," "Congenital Hemorrhage," "Congenital Jaundice," "Congenital Tetanus," "Congenital Erysipelas," "Congenital Sclerema," "Congenital Atelectasis," "Congenital Ossific Endocarditis," "Congenital Pericarditis," "Congenital Spinal Disease," "Congenital Brain Disease," "Congenital Meningitis," "Congenital Hernia," "Congenital Ulcer," "Congenital Abscess," "Congenital Tumor," "Congenital Cancer," "Congenital Gangrene," "Congenital Blood Poisoning," "Congenital Erysipelas," "Congenital Rheumatism," "Congenital Bowel Trouble," "Congenital Stomach Trouble," "Congenital Lung Disease," "Congenital Liver Disease," "Congenital Kidney Disease," "Congenital Heart Disease," "Congenital Dropsy," "Congenital Consumption," "Congenital Inflammation," "Congenital Womb Trouble," "Congenital Rheumatism," "Congenital Erysipelas," "Congenital Blood Poisoning," "Congenital Gangrene

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56624

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 S Callington Ave ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm O Gordy.

(a) RESIDENCE. No. 226 S. Callington ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Gordy

6 DATE OF BIRTH (month, day, and year): Jan 1840

7 AGE: Years 81; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mariner 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Salisbury Md

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Salisbury Md

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't know

14 Informant: Annie Gordy (Address) 226 S. Callington ave

15 Filed Robert F. Harrison, Registrar

Burial Permit Clerk.

2-1921

CAUSE OF DEATH. Be particular and exact. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1921, to Aug. 31, 1921, that I last saw h[illegible]m alive on Aug 31, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Atherosclerosis 0 720

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary): Paralysis of respiration

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Hugh Forsythe, M. D.

19 (Address) 1214 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Sept 3 1921

20 UNDERTAKER: Robt J Turner Inc

ADDRESS: 1412 N. Howard

UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably a terminal cerebral hemorrhage.

Spec.—1-10-21—M&T—1500 Bks.

(Famme)

D 56625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56625

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 32 E. Hamilton Ave ST., 41 WARD)

2-FULL NAME Charles Famme

(a) RESIDENCE NO. 32 E. Hamilton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence G. Famme

6 DATE OF BIRTH (month, day, and year): March 22nd 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 009

(b) General nature of Industry, business, or establishment in which employed (or employer): Clothing

(c) Name of employer: Nehoss Bros.

9 BIRTHPLACE (city or town) (State or country): Balto. Maryland.

PARENTS

10 NAME OF FATHER: August Famme

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hanover Germany

12 MAIDEN NAME OF MOTHER: Mata Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bremen Germany

14 Informant (Address): August Famme 32 E. Hamilton ave.

15 Filed SEP 2 - 1921, 19 ..... Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 31 1921

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1921, to Aug 31, 1921.

that I last saw him alive on Aug 31, 1921, at 12.45 P. m.

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.

CONTRIBUTORY (Secondary) Mitral Regurgitation (duration) ... yrs. ... mos. ... ds.

Rheumatic arthritis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carl Famme M. D.

Aug 31, 1921 (Address) 4706 Harford Ca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Cemetery

DATE OF BURIAL: Sept 3 1921

20 UNDERTAKER: Frank Loeschner & Sons

ADDRESS: Fullerton Md.

IMPORTANT—Write CAUSE OF DEATH in plain terms. See instructions on back of certificate. CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Blks.

D 56626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56626

CERTIFICATE OF DEATH

REGISTERED NO. 15

1-PLACE OF DEATH West End Maternity

CITY OF BALTIMORE: (No.) 112 Calliou ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby King.

(a) RESIDENCE NO. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1 1921

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West End Maternity Baltimore Md.

PARENTS

10 NAME OF FATHER George H. King.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ethel White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Geo H King

(Address) 112 W. Franklin St

15 Filed SEP 2-1927, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Birth Sept. 1, 1921, to death Sept. 1, 1921, that I last saw him alive on Sept. 1, 1921, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) yrs. 2 mos 7 ds.

CONTRIBUTORY (Secondary) Rapid delivery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Bernard Purnell Nurse M. D.

9/2, 1927 (Address) 103 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Sept 3 1921

20 UNDERTAKER J. J. Mitchell

ADDRESS Franklin St

Spec.—1-10-21—M&T—1500 Blks.

D 56627

HEALTH DEPARTMENT—CITY OF BALTIMORE

138 ✓ D 56627

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West End Maternity

CITY OF BALTIMORE: (No. 112 Calhoun ST., 20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ethel King,

(a) RESIDENCE NO. 2000 W. Franklin ST., ✓ WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George H King

6 DATE OF BIRTH (month, day, and year): Dec 7 - 1890

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
30	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo H Little

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Geo H King. (Address): 2000 W Franklin St

15 Filed ....., 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk

SEP 2 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st A.M. 1921 to Sept 1 P.M. 1921.

that I last saw h alive on Sept 1 1921.

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Toxemia of Pregnancy

(duration) yrs. 2 mos t ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 2000 W. Franklin

Did an operation precede death? yes Date of Sept 1 1921

Was there an autopsy? no

What test confirmed diagnosis? Hosp. Laboratory

(Signed) Bernard Philip Mann, M. D.

9/2 1924 (Address) 1037 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 3 1921
20 UNDERTAKER	ADDRESS
J J Mitchell	1231 W Fayette

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 56628

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56628

CERTIFICATE OF DEATH.

64

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3034 Annah Ave ST., 16 WARD)

2-FULL NAME Emma Jane Snyder

(a) RESIDENCE NO. 3034 Annah Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eli H. Snyder

6 DATE OF BIRTH (month, day, and year) Oct 31 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Littlestown (State or country) Pa

PARENTS

10 NAME OF FATHER John Spangler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Caroline Vanderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Eli H. Snyder (Address) 3034 Annah Ave

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

SEP 2 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 9th, 1921, to Sept 1st, 1921, that I last saw her alive on Sept 1st, 1921, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. ... mos. 22 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no. — none

What test confirmed diagnosis?

(Signed) Chas. H. Burkert M. D.

(Address) 1100 W. Lafayette Ave Sept. 1st 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem DATE OF BURIAL Sept 2 1921

20 UNDERTAKER Wm Tucker Sons ADDRESS Mondawmin

CAUSE OF DEATH in plain terms, so that it can be understood by any one. Do not use abbreviations or technical terms. See instructions on back of certificates. TION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56629

CERTIFICATE OF DEATH.

119

D 56629

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 W. Fayette st ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Louise Johnson

(Residence in Baltimore: No. 1424 W. Fayette St St.; 65 yrs., 4 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Divorced

6-DATE OF BIRTH, September (Month) 2nd (Day), 1921 (Year)

7-AGE, 65 yrs. 4 mos. 12 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. John Thomas Johnson

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Jane Reese

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Trimble Turner

(Address) 2218 Hayelot ave

15- Filed SEP 2 1921, 191.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 2nd (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1921, to September 2 1921, that I saw her alive on September 1st 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) — — 14 ds.

CONTRIBUTORY (Secondary) (Duration) — yrs. — mos. — ds.

(Signed) Robt. G. L. Lumpkin M. D.

Sept 2nd, 1921. (Address) 11 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lt. Olivet Cemetery

DATE OF BURIAL, Sept. 5 1921

20-UNDERTAKER George J. Smith

ADDRESS 808 W Fayette St.

PP CAUSE OF DEATH important. See instructions on back of certificate.

No other abnormal condition than possible use of stimulants

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec. 6-9-19—H. P. Co.—1000 Bks.

(Kimmelshue)

150395
D 56630

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56630

+63-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Kimmelshue

(a) RESIDENCE. NO. 1 Lucile Lane Catonsville ST. WARD. Catonsville Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. [illegible] mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 29. 917.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Maryland

PARENTS

10 NAME OF FATHER Marion E. Kimmelshue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura Schnarty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed Robert P. Harrison, Registrar

SEP 2-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2. 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 30 1921, to Sept. 2 1921, that I last saw h. Ez alive on Sept. 2nd 1921, and that death occurred, on the date stated above, at 7:40 a m.

The CAUSE OF DEATH* was as follows:

Poliomyelitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) none -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home -

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? Lumbar puncture.

(Signed) Horace G. Stewart, M. D.

9-2-21 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salem Cemetery

DATE OF BURIAL Sept 3 1921

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

CAUSE OF DEATH in plain terms. Abbreviations not allowed. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56631

D 56631

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Main St. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Hickenbotham

(a) RESIDENCE. NO. 1303 Main St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 5 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice M. Hickenbotham

6 DATE OF BIRTH (month, day, and year): Apr. 23rd 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housepainter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm. H. Hickenbotham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Philadelphia Pa.

12 MAIDEN NAME OF MOTHER: Elizabeth Schockly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Salisbury Md.

14 Informant (Address): Mrs. Alice M. Hickenbotham 1303 Main St.

15 Filed . 19 Robert P. Harrison, Registrar

EP 2 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from June . 1921 , to Sept 1 . 1921 .

that I last saw him alive on Aug 29 . 1921 .

and that death occurred, on the date stated above, at 2.50 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): Edema of Lungs

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical Signs

(Signed) H. O. Smith, M. D.

. 19 (Address) 189 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 3rd 1921
20 UNDERTAKER: Joseph B. Cook	ADDRESS: 1013 N. Calvert St

mation should be given in plain terms, so that it may be clearly understood. CAUSE OF DEATH in plain terms, so that it may be clearly understood. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56632

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56632

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Irene Swartz

(a) RESIDENCE. NO. 1110 Guilford Ave ST., WARD. R. 26 - 2nd Hall

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles. E. Swartz

6 DATE OF BIRTH (month, day, and year) 12-27-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46	-	8	4	

8 OCCUPATION OF DECEASED 009

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Not employed Balto.

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Wm J. Keith

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys County

12 MAIDEN NAME OF MOTHER Marella Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Co.

14 Informant Mrs. F. G. Keith

(Address) 1110 Guilford Ave

15 Filed 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

SEP 2 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31-1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1921, to Aug 31, 1921, that I last saw her alive on Aug 31, 1921, and that death occurred, on the date stated above, at 8.35 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank. C. Marino, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Sept 3 1921

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N Balto St

IMPORTANT: Fill out CAUSE OF DEATH in plain terms, and see that PHYSICIAN fills out MEDICAL CERTIFICATE. See instructions on back of certificate. CAUSE OF DEATH is very important.

Spec.—5-19-13—M. & T.—500 Bks.

D 56633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56633

CERTIFICATE OF DEATH.

63-001

REGISTERED NO. C

1-PLACE OF DEATH Ravenswood Ave Evans 27

CITY OF BALTIMORE: (No. Harford Ave ST.; (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton Reynolds

(Residence in Baltimore: No. Harford Ave St.; yrs., 19 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Blk	Sngle

6-DATE OF BIRTH. March 31, 1919. (Month) (Day) (Year)

7-AGE. yrs. 19 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 800

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. S. L. Reynolds

11-BIRTHPLACE OF FATHER. (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER Hattie Mandly

13-BIRTHPLACE OF MOTHER. (State or Country). North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. L. Reynolds

(Address) Same

15- Filed SEP 3 - 1921 191 ROBERT J. KRAUTER Registrar Burial Permit Issued

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 2, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 30 1921, to Sep 2 1921, that I saw him alive on Sept 2 1921, and that death occurred, on the date stated above, at 10.55 A.m.

The CAUSE OF DEATH* was as follows: Acute poliomyelitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bulbar Paralysis 5 hrs

(Duration) yrs. mos. ds.

(Signed) G. W. T. Bishop M. D.

Sep. 2, 1921 (Address) 501 Sheridan Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. mos. ds. In the State yrs. 19 mos. ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same.

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cem. DATE OF BURIAL. Sept. 4 1921

20-UNDERTAKER Chas. H. Johnson & Co. ADDRESS N. Carolina

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56634 150 D 56634

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3626 Park Av ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecil Melvin Lusk

(a) RESIDENCE. NO. 3626 Park Av ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? — yrs. 2 mos. 22 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) June 10 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER George L. Lusk

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elenor Morrison

13 BIRTHPLACE OF MOTHER (city or town) Warren (State or country) Virginia

14 Informant George L. Lusk (Address) 3626 Park Av

15 Filed . 19 ROBERT J. KRAUTER Registrar

SEP 3 - 1921 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1921, to Sept 2, 1921, that I last saw him alive on Sept 1st, 1921, and that death occurred, on the date stated above, at 2.05 P. m.

The CAUSE OF DEATH* was as follows:

Cardia Insufficiency

(Latent Formerly Ovale)

(duration) Since Birth yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) W. D. Gillick, M. D.

9/3 1921 (Address) (N. 2) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Sept 5th 1921
20 UNDERTAKER William H. Higgins	ADDRESS 3624 Park Av

N. B.—Information should be carefully supplied. And it may be properly classified. Each CAUSE OF DEATH in plain terms, so that it may be of certificates. TION is very important. See instructions on back of cer

D 56635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159 D 56635

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles E. Clements

(Residence in Baltimore: No. 427 East 20th St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Nov 23, 1865
(Month) (Day) (Year)

7-AGE, 56 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Box Sawyer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER John W. Clements

11-BIRTHPLACE OF FATHER (State or Country) A. A. Co Md

12-MAIDEN NAME OF MOTHER Margaret ?

13-BIRTHPLACE OF MOTHER (State or Country) A. A. Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William L. Dallam

(Address) 427 East 20th

15- SEP 3 - 1921 Filed ..... 191.. ROBERT J. KRAUTER Registrar.

Burial Permit [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol
Shot, [illegible] wounds
in brain (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Wiley (Coroner.) M. D.

Sept 3, 1921. (Address) 1639 Bradley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Cemetery

DATE OF BURIAL, Sept 5, 1921

20-UNDERTAKER William Cook

ADDRESS 504 E North Ave

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-3-19—H. P. Co.—1000 Bks.

D 56636

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56636

CERTIFICATE OF DEATH.

135

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 726 S Hanover ST.; 22 WARD)

2-FULL NAME Daisy Smith

(a) RESIDENCE. NO. 726 S. Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married.

5a If married, widowed, or divorced (or) WIFE of Charles Smith.

6 DATE OF BIRTH (month, day, and year) Aug. 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer

9 BIRTHPLACE (city or town) Georgetown (State or country) South Carolina

PARENTS

10 NAME OF FATHER John Lomis

11 BIRTHPLACE OF FATHER (city or town) (State or country) S Carolina.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S Carolina

14 Informant Charles Smith (Address) 726 S Hanover St.

15 Filed SEP 3 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 2, 1921, that I last saw her alive on Sept 2, 1921, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Post partum Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morris Reese, M. D.

9 2, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Sept 4 1921
20 UNDERTAKER	ADDRESS
A. V. Brown's Son	108 N. Mon[illegible]

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Burial Permit Issued

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56637

CERTIFICATE OF DEATH.

79 D 56637

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. St.: 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Emery / EMERY

(a) RESIDENCE. No. 1221 E. Eagles St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced, HUSBAND of ~~WIFE of~~ Mrs. John H. Emery (a)

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Manufacturing Chemist

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Samuel Emery

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Hanover Co. N.C.

12 MAIDEN NAME OF MOTHER Mary E. Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant J. Ralph Emery
(Address) 1014 Cathedral St.

15 Filed SEP 3 - 1921 19 ROBERT J. KRAUTER Registrar
Social Service Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1921, to Sept. 2, 1921, that I last saw h/m alive on Sept. 2, 1921, and that death occurred, on the date stated above, at 4.17 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

Where was disease contracted if not at place of death? Balto.

Was ~~wife of~~ widow of deceased ever pregnant? No Date of delivery

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George E. W. Hardy, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 3 1921

20 UNDERTAKER ADDRESS

John O Mitchell 1201 W Fayette St

CAUSE OF DEATH ... TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56638

CERTIFICATE OF DEATH.

37 D 56638

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 18 WARD)

2-FULL NAME Antonio Balsamo

(a) RESIDENCE. NO. 1223 W. Baltimore St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? Dont Know mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Mrs Balsamo

6 DATE OF BIRTH (month, day, and year) June 13 - 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	abt 38	—	—	

031

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist Helper -

(b) General nature of industry, business, or establishment in which employed (or employer) Machine Work -

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Dont Know Italy

10 NAME OF FATHER V. Michael Balsamo

11 BIRTHPLACE OF FATHER (city or town) Dont Know (State or country) Italy

12 MAIDEN NAME OF MOTHER Frances Scelio

13 BIRTHPLACE OF MOTHER (city or town) Dont Know (State or country) Italy

14 Informant Record & Ret Hospital (Address) Mt Hope & Md.

15 Filed SEP 3 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 28th, 1921, to Sept 2nd, 1921, that I last saw him alive on Sept 1st, 1921, and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows: Paresis - (Luetic) (Eclamptic)

History Given abt (duration) 6 yrs. mos. ds.

Personal Knowledge 5 days - Paretic Mania

CONTRIBUTORY (Secondary) Over 5 days - (duration) 4 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frank J Flannery, M. D.

Sept 2nd, 1921 (Address) Frank J Flannery -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Catholic Cem	9-5 1921

20 UNDERTAKER Robt Burns & Son

ADDRESS Baltimore W

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6

REGISTERED NO. D 56639

D 56639

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 Bank ST.: 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Desfeaux

(a) RESIDENCE. No. 2012 Bank ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 9/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Laura Desfeaux

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Adam Desfeaux (Address) 2012 Bank

15 Filed SEP 3 - 1921 . 19 BOLEY J. LAUTER Registrar Carl J. Parnell Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 3, 1921, that I last saw him alive on Sept 3, 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions Acute Dilatation Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A L Tumbleson, M. D.

9/3. 1921 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL I A German — DATE OF BURIAL Sept 3 1921

20 UNDERTAKER Peter Nicolaos — ADDRESS 2046 East Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Brendell.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56640

40

D 56640

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH New City Hospital

CITY OF BALTIMORE: (No.) ..... ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Brendell

(a) RESIDENCE. NO. 709 Castle St ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 24 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) 140

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Brendell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M. Kengel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hosp. Record
(Address)

15 Filed SEP 3 - 1921, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2-1921

17 I HEREBY CERTIFY, That I attended deceased from 8-15, 1921, to 9-2, 1921, that I last saw him alive on 9-2, 1921, and that death occurred, on the date stated above, at 7.50 A m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma Abd.

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopay? .....

What test confirmed diagnosis? .....

(Signed) Clyde McNeal, M. D.

9-2, 1921 (Address) New City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sep 3 1921
20 UNDERTAKER Wendell Oppel & Son	ADDRESS 573 N

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

BOARD OF HEALTH
Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

56641

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56641

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) New City Hospital ST.: 56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Mohammet

(a) RESIDENCE. NO. Bay View ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inmate

(b) General nature of industry, business, or establishment in which employed (or employer) Bay View

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Else Devine

(Address) 421 St Mary's St

Filed SEP 9 — . . 19 . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1921

17 I HEREBY CERTIFY, That I attended deceased from 9—1—1921 to 9—1—1921

that I last saw her alive on Sept 1, 1921

and that death occurred, on the date stated above, at 6:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

9-1-1921 (Address) New City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL Sept 3 1921

20 UNDERTAKER Charles T Thursby ADDRESS 547 Bradford

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co.—1000 Blks.

56642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56642

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 Falls Rd ST.: 13 WARD)

REGISTERED NO. 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Lee Brown

(a) RESIDENCE. NO. 234 Falls Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar, 1910

7 AGE	11 Years	5 Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas Henry Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lydia Mae Dijon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lydia Mae Brown
(Address) 234 Falls Rd

15 Filed SEP 3 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from July - 1 - 1921, to Sept 1, 1921, that I last saw him alive on Sept 1, 1921, and that death occurred, on the date stated above, at 5.45 p m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Aortic Stenosis ?

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Stethoscopic

(Signed) Edw Short M. D.

9/3 1921 (Address) 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Sept 3 1921

20 UNDERTAKER Samuel Kemsley ADDRESS 518 Bidde

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56643

D 56643

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. 2623 Edmondson Avenue ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Justine Frances Shettle

(a) RESIDENCE. NO. 2623 Edmondson Ave. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Shettle

6 DATE OF BIRTH (month, day, and year) Jan. 15, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None ///

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER Theodore Delevigne

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER Mary Mannion

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Ella L. Taylor

(Address) 2623 Edmondson Avenue

15 Filed SEP 3 - 1921 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25th, 1921, to. Sept 2nd, 1921.

that I last saw h[illegible] alive on Aug 31st, 1921.

and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
Mitral incompetency
Decompensation

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary): none known

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Stethoscopy

(Signed) Chas J. Keller, M. D.

9/3/ 1921 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	9/5 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56644

REGISTERED NO. 37

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. 5 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Gorman

(a) RESIDENCE. NO. 101 East ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie Gorman

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bay View Hospital Baltimore Md.

15 Filed SEP 3 - 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1. 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1921, to Sept 1. 1921, that I last saw h alive on Sept 1. 1921, and that death occurred, on the date stated above, at 2 25 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (3 yrs Chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Cirrhosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) H. F. Gosnell M. D.

9/7/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL Sept 3 1921

ADDRESS 1502 Eastern Ave

20 UNDERTAKER John W Henderson

CAUSE OF DEATH in plain terms, ... on back of certificates. TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56645

D 56645

CERTIFICATE OF DEATH.

X150

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Saffel Saffel

(Residence in Baltimore: No. 2038 Brookfield Ave St.; ....yrs., 7 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	S

6-DATE OF BIRTH, Feb (Month) 3 (Day), 1914 (Year)

7-AGE, ...yrs. 7 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Elkins W Va

PARENTS.

10-NAME OF FATHER, Delbert W. Saffel

11-BIRTHPLACE OF FATHER (State or Country) Barbour Co W Va

12-MAIDEN NAME OF MOTHER Lelia A Poe

13-BIRTHPLACE OF MOTHER (State or Country), Elkins W Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15- GG

Filed SEP 3 - 1921 191.... Registrar.

N. B.—Every item must be filled in plain terms, so that it may be plain. CAUSE OF DEATH in plain terms, so that if may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 3 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Sept 3 1921, that I saw her alive on Sept 3 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Post operative Shock

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Moses Paulson M. D.

9/3, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. 3 ds. In the State ....yrs. 7 mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Elkins W Va

DATE OF BURIAL, 9/4, 1921.

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

D 56646

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 1720 56646

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. John Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Glancy

(Residence in Baltimore: No. Fort Howard, Md. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. Unknown (Month) ....., 1 (Day) (Year)

7-AGE. 22 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)..... U S A

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country). "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Fort Howard Records
(Informant).....
(Address).....

15- Filed SEP 3 — 1921 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Traumatism Skull
U S Army
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C K Insley M. D.
(Coroner.)
9-3-, 1921. (Address) U S Govt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Washington, D.C.	Sept. 3 — 1921
20-UNDERTAKER Jack Kenny	ADDRESS E. Balto. St.

CAUSE OF DEATH in plain terms, so that it may be easily understood. All items important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

56647

HEALTH DEPARTMENT—CITY OF BALTIMORE

79-91 B 56647

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE (No. 26 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry [redacted] Abbott.

(a) RESIDENCE. NO. [redacted] ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or WIFE of) [redacted]

6 DATE OF BIRTH (month, day, and year) Aug 28 (1868)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER [redacted]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [redacted]

12 MAIDEN NAME OF MOTHER [redacted]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [redacted]

14 Informant [redacted] (Address) Bay View Hospital Baltimore Md.

15 Filed SEP 3 - 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1921, to Sept 2, 1921, that I last saw h[redacted] alive on Sept. 2, 1921, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (Chronic)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. Frederick, M. D.

1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Sept 5 1921

20 UNDERTAKER Bertram Cook — ADDRESS [redacted]

CAUSE OF DEATH ... See instructions on back of CERTIFICATE. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56648

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 56648

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 344 Carrel ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Ringgold

(Residence in Baltimore: No. 344 Carroll St.: 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. June (Month) 2 (Day) 1849 (Year)

7-AGE. 72 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Isaac Ringgold

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Myles

(Address) 705 N. Franklin St.

15- SEP 3 - 1921 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 1 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15th 1921, to Sept. 1 1921, that I saw h— alive on Sept. 1 1921, and that death occurred, on the date stated above, at 7 P.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sclerosis

(Duration) 1 yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 7 yrs. mos. ds.

(Signed) A. Lee Claytor M. D.

Sept. 2, 1921. (Address) 924 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn

DATE OF BURIAL. Sept. 4, 1921.

20-UNDERTAKER Kate R. Williams

ADDRESS 1114 W. Saratoga

(See instructions on back of certificate. Important.)

Stmt. 6-9-19—H. P. Co.—1000 Blks.

D 566 49 — 50077 — X.54 D 566 49

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.: ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sally May Carter.

(a) RESIDENCE. NO. Ridgely Md ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos 19 ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Edward B Carter Ridgely Md.

6 DATE OF BIRTH (month, day, and year) May 31- 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home. wife.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Caleb Scattergood

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Amy E. Gilda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) Johns Hopkins Hospital. Baltimore

15 Filed SEP 3 - 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 14. 1921. to Sept 2. 1921.

that I last saw her alive on Sept 2. 1921.

and that death occurred, on the date stated above, at 10 35 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia.

(duration) 2-3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ——

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? cannot say.

Did an operation precede death? no Date of

Was there an autopsy? yes Blood tests

What test confirmed diagnosis?

(Signed) D I Brannan M. D.

9-3-21 19 (Address) Johns Hopkins Hospital City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Pa — DATE OF BURIAL: 9/3/21 19

20 UNDERTAKER A E Hughes 424 N Broadway — ADDRESS

CAUSE OF DEATH in plain English. Do not use abbreviations or technical terms. See instructions on back of certificate. TION is very important.

D 56650

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56650

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Lydia Benson

(Residence in Baltimore: No. 4100 Groveland Ave. 25 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH. May (Month) 7 (Day), 1867 (Year)

7-AGE. 54 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Bell Keeper 98

(b) General nature of industry, business, or establishment in which employed (or employer). House Building Co.

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Edward I. Benson

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Eliza Stewart

13-BIRTHPLACE OF MOTHER (State or Country). Baltimor Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Clara Wilson

(Address) 416 St Paul Park Ave

15- Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 2 (Day), 1911 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, au- ..... find that said deceased came to ..... death topsy or inquiry.) on the day stated above.

will to take place Sept 5-11

The CAUSE OF DEATH* was as follows: Acute Mitralinsufficiency Valvular Heart Disease Stenosis Contributory Sept 2 (Duration) 17 yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Tilley M. D.

Sept 3, 1911 (Address) 1057 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 1 day mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. Royal Oak Talbot Co Md

DATE OF BURIAL. 9/4/11, 19....

20-UNDERTAKER H E Hughes

ADDRESS 1211 N. Broadway

SEE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

RP 1911
EP 998

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56651

CERTIFICATE OF DEATH.

REGISTERED NO. 479

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4038 Park Heights ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ecclestia Mc Nally

(a) RESIDENCE. No. 4038 Park Heights ST.,

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Mc Nally

6 DATE OF BIRTH (month, day, and year) Sept 1839

7 AGE 82 Years Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Thomas Doohan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mount

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Matthew M. Doohan

(Address) Avon P. O. Virginia

15 Filed Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1921, to Sept 2, 1921, that I last saw her alive on Sept 2, 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows: 430

Mutral Valvular Lesion.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? I don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Edmund

(Signed) Wedgewood M. D.

9/9/1921 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nat. Cathedral Sept 5th 1921

DATE OF BURIAL

20 UNDERTAKER: Geo. Weber & Son

ADDRESS 2503 Edmonds ave

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

SEP 4 1921 Burial Permit, Clerk.

(Anderson)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56652

152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 315 N. Appleton ST.: 18 WARD)

2-FULL NAME Mary Anderson.

(a) RESIDENCE. NO. 315 N. Appleton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 30 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Emma Buck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Emma Buck
(Address) 315 N. Appleton st

15 Filed Sept 4 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept. 2, 1921, that I last saw her alive on Sept. 2, 1921, and that death occurred, on the date stated above, at 3.30 m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) L. J. Rigney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	Sept 4 1921
20 UNDERTAKER	ADDRESS
Brownwell Fulland	Schroder

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 CD 56653 — 104 — V 151 — D 56653

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hospital (St.:) 76 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wanda Mengert

(a) RESIDENCE. NO. 616 S 12th St (St.,) (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1921

7 AGE Years 3 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Mengert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Brauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

P 4 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to Sept 3, 1921.

that I last saw h[illegible]ive on Sept 3, 1921.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Horace G. Stewart, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md

DATE OF BURIAL Sept 5 1921

20 UNDERTAKER Joseph ahrens

ADDRESS 221 B Way

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56654

D 56654

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2227 Bank ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Rowny

(a) RESIDENCE. NO. 2227 Bank ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Alexander Rowny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Casmira Siadkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Alexander Rowny 2227 Bank St

15 Filed Sep 4 1921 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 3, 1921, that I last saw h[illegible] alive on Sept 3, 1921 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Dilation, (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Rand M. D.

Sept 4 1921 (Address) 8 E Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Sep 5 1921

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

CAUSE OF DEATH IS VERY IMPORTANT. See Instructions on Back.

D 56655

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56655

CERTIFICATE OF DEATH.

135

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Joseph's Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Millenski

(Residence in Baltimore: No. 1629 Aliceanna St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, Nov. (Month) 1 (Day) (Year)

7-AGE, 33 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Jan Millenski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Millenski

(Address) 1629 Aliceanna

15-

Robert P. Harrison,

Filed....., 191..... Registrar.

SEP 4 - 1921 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Placenta Previa

Hemmorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank J. Wilkes M. D.

(Coroner)

9-3, 1921. (Address) W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary | DATE OF BURIAL, Sept. 5, 1921

20-UNDERTAKER John M. Weber | ADDRESS 1903 Bank St

D 56656 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56656

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Mercy Hospl. ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alex. Davis

(Residence in Baltimore: No. ~~May St~~ 821 Ashland Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Col'd	~~Single~~ Married

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 26 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lab.
(b) General nature of industry, business, or establishment in which employed (or employer): 40

9-BIRTHPLACE, (State or Country), U. S. C.

PARENTS.

10-NAME OF FATHER, Alex. Davis

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Amelia Barton

13-BIRTHPLACE OF MOTHER (State or Country), S C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. Davis

(Address) 821 Ashland Av

15- Filed ....., 191.... Robert F. Harrison, Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

P 4-1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 2, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest~~ Autopsy (Inquest, autopsy or inquiry?) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Inquest will be held Sept 3rd. 1921

Gun shot wound in Chest.

about 1 week (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Riley M. D. (Coroner)

Sept 3, 1921 (Address) 1657 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Asbury	Sept 3, 1921
20-UNDERTAKER John W Henderson & Monument	ADDRESS 1502

Accidentally shot by another.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.--8-24-14—M. & T.—2000 Bks.

D 56657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56657

CERTIFICATE OF DEATH.

170

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 S Bethel St ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Hamlin

(Residence in Baltimore: No 118 S Bethel St St.; 30 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, unknown — (Month) (Day), 1876 (Year)

7-AGE, 45 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Store keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 04W

9-BIRTHPLACE, (State or Country), Atlanta Georgia

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Atlanta Georgia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Hamlin

(Address) [illegible]

15- 118 S. Bethel St

Filed Robert F. Harrison, 191... Registrar.

P 4-1921 Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 1 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1921, to Sept 1 1921, that I saw him alive on Sept 1 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Degeneration

(Duration) ...yrs.....mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(Duration) ...yrs. 2 mos.....ds.

(Signed) Richard H. Essinger M. D.

Sept 2 1921 (Address) 1746 Baltimore Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cemetery DATE OF BURIAL, Sept. 4. 1921

20-UNDERTAKER Milton Davis ADDRESS 317 N. Eden St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56658 47 D 56658

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2702 N.Charles Street ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas W.Marshall

(a) RESIDENCE. NO. 2702 N.Charles Street ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Marshall

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lead Burning Business

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Bixby & Marshall

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Henry Jones
(Address) 2702 N.Charles St.

15 Filed SEP 4 - 1921 [illegible] Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1921, to Sept 2, 1921, that I last saw him alive on Sept 2, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum (?)
Liver metastasis
Intestinal obstruction

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Senile gangrene Leg

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Apr. 20. 21.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. L. Jennings, M. D.

, 19 (Address) 1800 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 5 19 21
20 UNDERTAKER	ADDRESS
Chas.F.Evans & Son	118 W.Mt.Royal

TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56659

CERTIFICATE OF DEATH.

81 D 56659

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5005 Wilson Ave. ST.: 27 WARD)

2-FULL NAME John F. Shoop

(a) RESIDENCE. NO. 5005 Wilson Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly Shoop

6 DATE OF BIRTH (month, day, and year) May 21-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 162

(c) Name of employer P. R. R.

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Samuel Shoop

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edwin D. Shoop
(Address) 5005 Wilson Ave.

15 Filed Robert F. Harrison Registrar
Burial Permit Clerk

SEP 4 - 1921

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2/21 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1921, to Sept 2, 1921, that I last saw him alive on Sept 2, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Heat Prostration
He was in bed

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum + Urine + Path

(Signed) Robt F Woodside M. D.

, 19 (Address) 7 Cleveland Square

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 9/5 1921

20 UNDERTAKER: Chas P. Evans & Son

ADDRESS: 118 W. Mt. Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 56660

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56660

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2340 Oak ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sue T. Crossmore

(Residence in Baltimore: No. 2340 Oak St.: 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Sept 6 (Month) (Day) 1873 (Year)

7-AGE: 48 yrs. 11 mos. 28 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: William Abrum

11-BIRTHPLACE OF FATHER (State or Country): Balto- Md.

12-MAIDEN NAME OF MOTHER: Margaret Stanton

13-BIRTHPLACE OF MOTHER (State or Country): London, England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mae T. Matthews

(Address) 2340 Oak St.

15- Filed SEP 4 1921, 191 Registrar.

Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Sept 3 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 14, 1921, to Sept 3 1921, that I saw her alive on Sept 2 1921, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Fall stunned

(Duration) yrs. 5 mos. ds.

(Signed) Bascom T. Cross M. D.

Sept. 3, 1921. (Address) 1138 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore

DATE OF BURIAL: Sept 6, 1921

20-UNDERTAKER: Zirkler & Zirkler

ADDRESS 1739 Eager

Important. See instructions on back of certificate.

Spec.—4-9-19—H. P. Co.—1000 Bks.

D 56661

HEALTH DEPARTMENT—CITY OF BALTIMORE

37 - 091 - D 56661

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2935 O'Donnell (St.:) 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Diven

(a) RESIDENCE. No. 2935 O'Donnell St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 4 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Minnie Diven

6 DATE OF BIRTH (month, day, and year) April 3, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk- Pa. R.R.

(b) General nature of industry, business, or establishment in which employed (or employer) 609

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George W. Diven

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co.

12 MAIDEN NAME OF MOTHER Minnie E. Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant (Address) Minnie Diven 2935 O'Donnell

15 Filed SEP 4 - 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from August 16, 1921, to Sept 1st, 1921, that I last saw him alive on Sept 1st, 1921, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows: OVER

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 18 ds.

CONTRIBUTORY (Secondary) Bronchio pneumonia

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual clinical symptoms

(Signed) Geo. W. Diven, M. D.

9/2, 1921 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Sept 5 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms. Do not use abbreviations or initials. Name of contagious disease is required. Omission to state the CAUSE OF DEATH in plain terms, as directed on the other side of certificates. See instructions on back of certificates. ATION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Luetic.

D 56662 ✓ D 56662

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Harford Ave ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Johnson

(a) RESIDENCE: NO. 706 Harford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	B	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) June 2nd 1868

7 AGE 53. Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Porter

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Alabammer Lie in Balt. Co.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant (Address) Miss Laura Johnson 706 Harford Ave

Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 , 1921

17 I HEREBY CERTIFY, That I attended deceased from March , 1921 , to Sept 1 , 1921 , that I last saw him alive on Sept 1 , 1921 , and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Parenchymatous nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ch. Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein , M. D.

9/3 , 1924 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Sept-4 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. MAKE ENTRIES WITH INK. TION is very important.

P4 1921

Spec. 6-9-19—B. P. Co.—1000 Blks.

14958 D 56663

HEALTH DEPARTMENT—CITY OF BALTIMORE D 56663

CERTIFICATE OF DEATH. 20

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.:) 10 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Sydnor

(a) RESIDENCE. No. 820 Ashland Ave St. Balto Co. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married.

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of wife of James Sydnor. same address

6 DATE OF BIRTH (month, day, and year) Dec 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Richard Francis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jane Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Johns Hopkins Hospital

15 Filed 9-7-1921 Robert F. Harrison, Registrar Burial ~~Permit~~ Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2. 1921

17 I HEREBY CERTIFY, That I attended deceased from July 17. 1921, to Sept. 2. 1921, that I last saw h[illegible] alive on Sept. 2. 1921, and that death occurred, on the date stated above, at 7 20 P. m.

The CAUSE OF DEATH* was as follows:

Stomatitis

0731

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 820 Ashland Ave.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W B Berman, M. D.

9-4. 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 5 1921
20 UNDERTAKER	ADDRESS
Wm—Jno Sr S Fink	1835 N Paca

CAUSE OF DEATH to be filled in plainly in ink or typewritten. See instructions on back of certificates. TION is very important.

P4 — 1921

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Lustic could not
get any other history.

D 56664

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 56664

REGISTERED NO. C 5V

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 333 S. Washington Ave. ST. V WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Josephine Seipert

(Residence in Baltimore: No. 333 Washington Ave St.: 1 yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: March 22, 1869 (Month) (Day) (Year)

7 AGE: 52 yrs. 5 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Samuel Stemmuch

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Kant Knew

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Frankel Seipert

(Address) 333 Washington Ave

15 Filed ..... 191 Robert P. Harrison, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 3, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to Sept 3 1921
that I saw her alive on Sept 2, 1921.
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. D. Smith M. D.

Sept 3, 1921 (Address) 301 S. Edward St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St. Stanislaus Cem. DATE OF BURIAL: Sept 6" 1921.

20 UNDERTAKER: M. J. Sadowski. ADDRESS: 705 S. Ann St.

N. B.-Every item of information must be given, so that it may be properly classified. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is very important. See instructions on back of certificate.

P 4 - 1921

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56665

150374
D 56665

CERTIFICATE OF DEATH.

14

REGISTERED No. 150374

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest E Race

(a) RESIDENCE. NO. 416 Lake Ave. ST.. WARD. ~~Harford Co.~~

(Usual place of abode) Baltimore MD

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Rachael Shoals~~ Eleanor M. Race

6 DATE OF BIRTH (month, day, and year) Oct 25 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 166

(b) General nature of industry, business, or establishment in which employed (or employer) Science

(c) Name of employer Md. State Normal

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Ethan C. Race

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER ~~Rachael~~ Martha Shoals

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant (Address) Johns Hopkins Hospital Baltimore

15 Filed [illegible] -1921 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 30 1921, to Sept 2 1921,

that I last saw him alive on Sept 2 1921,

and that death occurred, on the date stated above, at 8 05a m.

The CAUSE OF DEATH* was as follows:

Bleeding into Tumor of brain and from there into Ventricles. Brain Tumor one week (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Haemorrhage — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Emil Holman, Mr D

9-7-21 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greene N.Y	Sept 5 1921
20 UNDERTAKER Wm J Rickey & Sons	ADDRESS N & Pa

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

(Spicer). ✓

D 56666 D 56666

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 N Carey ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Spicer

(a) RESIDENCE. NO. 611 N Carey ST., 16 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John Spicer

6 DATE OF BIRTH (month, day, and year) 7/4/1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	1	24	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ellicott City (State or country) Md

PARENTS

10 NAME OF FATHER Wm Conway

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Ruth Cheney

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs. Nellie Cooney (Address) 611 N Carey St

15 Sept 4 1921 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1921, to Sept 2, 1921, that I last saw her alive on Sept 2, 1921, and that death occurred, on the date stated above, at 11:10 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Senile Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) John F Swarp M. D.

. 19 (Address) 1002 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sewage Church Cemetery Sewage Md,	Sept 5 1921
20 UNDERTAKER George D Smith	ADDRESS 1000 [illegible]

CAUSE OF DEATH in plain terms. No abbreviations or terms of uncertainty. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56667

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56667

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 947 W Fayette ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elizabeth Woodrow

(Residence in Baltimore: No. 947 W Fayette St.: 81 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Widowed

6-DATE OF BIRTH, May (Month) 5 (Day), 1840 (Year)

7-AGE, 81 yrs. 4 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balt.

PARENTS.

10-NAME OF FATHER, David Archer

11-BIRTHPLACE OF FATHER (State or Country) Harford Co Md.

12-MAIDEN NAME OF MOTHER Sarah A Durham

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ida L Woodrow Boatwright

(Address) 947 W Fayette St

15- Robert F. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

1927

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21 1921, to Sept 3 1921, that I saw h.r alive on Sept 3 1921, and that death occurred, on the date stated above, at 5.15 m.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(Duration) ..... yrs. ..... mos. 2 da.

CONTRIBUTORY (Secondary) Hemiplegia since

(Duration) ..... yrs. 1 mos. 20 da.

(Signed) John A Evans M. D.

Sept 23, 1921 (Address) 1011 N Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. Sept 6, 1921

20-UNDERTAKER George J Smith

ADDRESS 1000 E Fayette St

CAUSE OF DEATH must be filled in. See instructions on back of certificate.

P 4

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56668

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56668

CERTIFICATE OF DEATH.

130

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 Belnap ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert F. Murphy

(a) RESIDENCE. No. 101 Belnap ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 3- 1878

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Conductor 078
(b) General nature of industry, business, or establishment in which employed (or employer) Md Rwy Corp
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas Murphy
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Mary Murphy
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas E Murphy
(Address) 1112 Montpelier

15 Filed 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 1, 1921, that I last saw h... alive on Sept 1, 1921, and that death occurred, on the date stated above, at 10 Pm m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Int Nephr

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G F Frame, M. D.

, 19 (Address) 2113 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	Sept 5th 19 21

20 UNDERTAKER Harry H. Hartzler ADDRESS 1831 N Londo...

CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of certificates.

P 4 - 1921 Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56669

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Died at Church Home & Infirmary 708 N. Broadway

CITY OF BALTIMORE: (No. ~~2703 Fenwick Ave~~ ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hines

(a) RESIDENCE. NO. 2703 Fenwick Ave ST., WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary E. Heins

6 DATE OF BIRTH (month, day, and year) May 18 - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary E. Heins (Address) 2703 Fenwick Ave

15 Filed Sept 4 - 1921 16 Robert F. Harrison, Registrar Burial Permit Clerk.

CAUSE OF DEATH in plain terms. Indefinite answers will not be accepted. Information on back of certificates. TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from August 29, 1921, to September 3, 1921, that I last saw h(im) alive on September 3, 1921, and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Perforation

OVER

(duration) X yrs. X mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? yes Date of August 29, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cayetano Panettiere, M. D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Sept 7th 1921

20 UNDERTAKER William Cook

ADDRESS 502 E Wolfe St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day labgrer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to an old appendix abscess. Patient died at Church Home.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56670 (Berkein) D 56670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: ..... WARD) 2

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Berkein

(Residence in Baltimore: No. 1746 E. Lombard St.: 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1853 (Year)

7-AGE, 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 137
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Hebrew .....

(Address) ..... 1411 E. Balto. St. .....

15- Robert P. Harrison,

Filed ..... 1921 ....., 191.... Registrar.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1921, to Sept 4 1921, that I saw her alive on Aug 26 1921, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) { Cardiac Dilatation / Edema of Lungs

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Moses Davidson M. D.

....., 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 9 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Hebrew Cemetery

DATE OF BURIAL, Sept. 4, 1921

20-UNDERTAKER Jacob Levin

ADDRESS 1411 E. Balto

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56671

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56671

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 S. Carey St. ST.: 19 WARD)

2-FULL NAME Adam Beck

(a) RESIDENCE. NO. 132 S. Carey St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Beck

6 DATE OF BIRTH (month, day, and year) Aug. 27" 1842

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Harry A. Richardson 309 S. Calhoun St.

15 Filed Robert, I. Harrison, Registrar

9-4-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1" 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1921. to Sept 1 1921. that I last saw h[illegible] alive on Aug 31 1921. and that death occurred, on the date stated above, at 9.50P. m.

The CAUSE OF DEATH* was as follows: Cardio-failure

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? Atkinson (duration) yrs. mos. 30 ds.

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/3. 1921 (Address) 1302 N. Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Sept 5" 1921

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N Bolton St

Information should be careful, complete, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 56672

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56672

CERTIFICATE OF DEATH.

81

(PLACE OF DEATH

CITY OF BALTIMORE (No. 2120 Herbert ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-FULL NAME Annie Smith

(Residence in Baltimore: No. 2120 Herbert St.; yrs. 1, mos. 3, ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, November 7th., (Month) (Day), 1840 (Year)

7-AGE, 80 yrs. 11 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country) North Bend, Md.

PARENTS.

10-NAME OF FATHER, Frederick Temple

11-BIRTHPLACE OF FATHER (State or Country), U. S.

12-MAIDEN NAME OF MOTHER Pricilla Smith

13-BIRTHPLACE OF MOTHER (State or Country), U. S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary F. Pierce

(Address) 2120 Herbert St.

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

P4-192

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 2nd, (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) Paralysis Right Side

(Duration) yrs. mos. 1 ds.

(Signed) H. Shields M. D. (Coroner.)

Sept 2, 1921 (Address) 43 W. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Sept 5th, 1921

20-UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Gay St.

Baltimore, Md. Oct. 4, 1921.

I do hereby make oath that the name of deceased, given on
timore City Health Department Certificate No. D-56672, as
ie Smith is not correct, same should be recorded as Ann Smith.

Mary F Price

Subscribed and sworn to before me this 4th day of October, 1921.

Reed Gaither
N. P.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56673

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 143 W. Lafayette ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan M. Fleming

(a) RESIDENCE. No. 143 W Lafayette ST., WARD.

(Usual) place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced (or) ~~wife~~ of Henry F. Fleming

6 DATE OF BIRTH (month, day, and year) June 2. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wheeling W Va

PARENTS

10 NAME OF FATHER Joseph Bushfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary McMackin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Henry L Fleming (Address) 143 W Lafayette

15 Filed Robert P. Harrison, Registrar

4 - 1927 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2d, 1927, to Sept 3rd, 1927, that I last saw h[illegible] alive on Sept 2nd, 1927, and that death occurred, on the date stated above, at 10:5 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Hypertension arteritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Gross symptoms & signs

(Signed) J. A. Blackard, M. D.

Sept 4 1927 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Sep 5 1927
20 UNDERTAKER	ADDRESS
John O. Mitchell	1301 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Bonne

56674 HEALTH DEPARTMENT—CITY OF BALTIMORE 56674

D 56674 D 56674

CERTIFICATE OF DEATH. 182

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 1700 Fort ave. St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Lee Bonne

(Residence in Baltimore: No. 1700 Fort ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE: 21 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mariner
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE (State or Country): Down.

PARENTS.

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (State or Country): Not Known

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (State or Country): Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mc Bannon

(Address) 1700 E Trust ave

15- Filed SEP 5 - 1921 191.. SOLEM J KRAUTER, Registrar.

COHONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 31, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by shot in mouth and brain

U S Pistol Cartridge

Sept 22 – Inquest held – Verdict suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) W J Riley (Coroner.) M. D.

Sept 2, 1921 (Address) 1639 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Rolfe Down — DATE OF BURIAL: 9/5/21 1921

20-UNDERTAKER: E J Deming & Son — ADDRESS: 1938 E Lafayette ave

N. B.—Every item of information should be carefully supplied. Accurate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 56675

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Forrest ST.: 10 WARD)

2-FULL NAME Emma Redmond

(a) RESIDENCE. No. 924 Forrest ST.. WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs mos ds

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information required in items 16 to 18 inclusive on back of certificates. TION is very important. See instructions on back.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Redmond.

6 DATE OF BIRTH (month, day, and year) June 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto— md

PARENTS

10 NAME OF FATHER David W. Cottman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriett Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Minnie Holmes

(Address) 924 Forrest St.

15 FILED SEP 5 - 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1921

17 I HEREBY CERTIFY, That I attended deceased from June 30 1921, to Sept 2 1921, that I last saw her alive on Sept 2 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? June 30 - 1921

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1920 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL Sept 6 1921

20 UNDERTAKER David Easton

ADDRESS 916 Pa ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56676

CERTIFICATE OF DEATH.

37 D 56676

D 56676
1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1618 Norwood Ave. ST.: 8 WARD)

2-FULL NAME Margaret. C. Streb

(a) RESIDENCE. No. 1618 Norwood Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry. P. Streb

6 DATE OF BIRTH (month, day, and year) Jan. 6. 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John. C. Byrnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dellia. C. Gildea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Henry P. Streb
(Address) 1618 Norwood Ave

15 Filed SEP 5 - 1921, 19 ROBERT P. BRUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept.-3-1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1921, to Sept 3, 1921.

that I last saw her alive on Sept 2, 1921.

and that death occurred, on the date stated above, at 11.20 A. M.

The CAUSE OF DEATH* was as follows:

Uremic Coma

over

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hayborn, M. D.

Sept 3, 1921 (Address) 1 E Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 6 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	130 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or terms peculiar to physicians. Information desired on back of certificates. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause not definite.
Suspicious of
lues.

I, E Randall M

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56677

CERTIFICATE OF DEATH.

91 D 56677

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 E Eager ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert J. Healy

(Residence in Baltimore: No. 841 E Eager St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, 5 (Month) 21 (Day), 1921 (Year)

7-AGE, ...yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John L. Healy

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Nora Wallis

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L. Healy

(Address) 841 E Eager St

15- Filed SEP 5 - 1921 191.... ROBERT A KRAUTER STATE REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-3 1921, to 9-4 1921, that I saw h.... alive on 9-3 1921, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 1 ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. Bernard West M. D.

9/7, 1921 (Address) 914 E. Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Sep. 5, 1921

20-UNDERTAKER Henry Brack & Son

ADDRESS 1301 E. Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item important. See instructions on back of certificate.

Spec.—1-10 21 M&T 1500 Bks.

D 56678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 D 56678

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 Forrest ST., 10 WARD)

2-FULL NAME Sophia H. Hentz

(a) RESIDENCE NO. 833 Forrest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimor

PARENTS

10 NAME OF FATHER William H Hentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Annie C. Green
(Address) 833 Forrest

15 Filed SEP 5 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 19, 1921, to Sept 2, 1921,

that I last saw her alive on Sept 2, 1921,

and that death occurred, on the date stated above, at 330 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) Arthur Hornstein, M. D.

9-4, 1921 (Address) 735 Presquile St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimor Cemtry — DATE OF BURIAL Sept 6 1921

20 UNDERTAKER William Cook — ADDRESS 502 E Nmith

CAUSE OF DEATH If plain words are used, there will be no difficulty in classifying the cause of death. Do not use abbreviations or technical terms. Consult the list of diseases on back of certificates. ATION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 56679

D 56679

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 252 - N - Bruce ST.: 19 (WARD)

2-FULL NAME Paul Rosco Alexander

(a) RESIDENCE. NO. 252 N. Bruce ST., 19 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25-? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ruth Chorothy Alexander

6 DATE OF BIRTH (month, day, and year) June 27 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	51	1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor 070
(b) General nature of industry, business, or establishment in which employed (or employer) Department Store
(c) Name of employer S. Wolpmans

9 BIRTHPLACE (city or town) (State or country) Mecklenburg Co Va

PARENTS

10 NAME OF FATHER Chas. Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mecklenburg Co Va

12 MAIDEN NAME OF MOTHER Louise Bros. Crosby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mecklenburg Va.

14 Informant Ruth Alexander
(Address) 252 N. Bruce St.

15 Filed SEP 5 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1921, to Sept 3, 1921, that I last saw him alive on Sept 3, 1921, and that death occurred, on the date stated above, at 2 10 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Wally Mackey M. D.

9/23, 1921 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Chapel Lakeview — DATE OF BURIAL: Sept 5 1921

20 UNDERTAKER: Frank T. Newsley — ADDRESS: 778 W. Baltimore

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10 21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 56680

CERTIFICATE OF DEATH.

56680

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 PARK AVE ST., 11 WARD)

2-FULL NAME JOSEPH LEE WILSON

(a) RESIDENCE NO. 1027 PARK AVE ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July-20-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ROBERT E. LEE WILSON

11 BIRTHPLACE OF FATHER (city or town) (State or country) GREEN BAY VIRGINIA.

12 MAIDEN NAME OF MOTHER HESTER BELL.

13 BIRTHPLACE OF MOTHER (city or town) PRINCE EDWARD (State or country) VIRGINIA.

14 Informant Robert E. Lee Wilson
(Address) 1027 Park Ave. Balto.

15 Filed SEP 5 - 1921 BOBBETT & BEAUTER Burial Permit Issued

CAUSE OF DEATH to be given on back of certificates. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1921, to Aug 30, 1921, that I last saw him alive on Aug 30, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pleurocolitis.

(duration) yrs. 1 mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1014 Union Ave, Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Percy M. Heath, M. D.

Sept 4 1921 (Address) 1766 Homestead St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Sept 5 1921

20 UNDERTAKER Felix B. Byrd

ADDRESS 102 E. Mulberry St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 56681

CERTIFICATE OF DEATH.

D 56681

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Preston & Valley Sts. ST.: 10 WARD)

2-FULL NAME Annie Wolf.

(a) RESIDENCE NO. Little Sisters of the Poor. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Wife Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Herman Wolf.

6 DATE OF BIRTH (month, day, and year) Mar 17-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59-	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Lambert?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Florence (Address) Preston Valley Sts.

15 Filed SEP 5 - 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 29 . 19 . to Sept 3 . 19 . 1921.

that I last saw h[illegible] alive on Aug 29 . 1921.

and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

2 weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

F. A. Warner, M. D.
(Signed)

Sept 3. 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Sept 5 1921

20 UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Fremont Av.

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48 D 56682

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1224 Marshall st. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Washenfelder

(a) RESIDENCE. No. 1224 Marshall st. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs mos. ds. How long in U. S., if of foreign birth? 20 yrs mos ds
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Philipine Washenfelder

6 DATE OF BIRTH (month, day, and year) Mar. 22 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cigar Maker 617
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. Philipine Washenfelder 1224 Marshall St.

15 Filed SEP 5 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 30 1921, to Sept 6 1921, that I last saw him alive on Sept 3 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

Sept 6 1921 (Address) 1644 Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Sep. 5 1921
20 UNDERTAKER J. Fenw Mc Gulley	ADDRESS 130 E. Fort

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 56683

D 56683

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3461 Cedar av ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Miller

(a) RESIDENCE. NO. 3461 Cedar av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M Miller

6 DATE OF BIRTH (month, day, and year) Jan 6 187[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	7	28	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Paver

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Spenzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Annie M Miller
(Address) 3761 Cedar ave.

15 Filed SEP 5 - 1921 RECEIVED [illegible] Registrar Vital Statistics Dept.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 19[illegible], to Sept 4, 19[illegible], that I last saw h[illegible] alive on Sept 3, 19[illegible], and that death occurred, on the date stated above, at 7.20 A m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Obstruction

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Gastric analysis

(Signed) [illegible] M. D.

, 19 (Address) # 11 W Cary St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Bur	Sept 6 1921

20 UNDERTAKER W. M. Routson

ADDRESS 2258 W Baltimore

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

115 D 56684

D 56684

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1011 Myrtle ave ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sophia Towson

(Residence in Baltimore: No. 1011 Myrtle ave St.; 68 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: May (Month) 10 (Day), 1853 (Year)

7 AGE: 68 yrs. 3 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9 BIRTHPLACE (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Jacobs

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Charlotte Wonder

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Katherine Towson

(Address) 1011 Myrtle ave

15 Filed SEP 5 - 1921 191 ROBERT J. KRAUSER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 3 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1921, to, Sept 2 1921, that I saw h[illegible] alive on Sept 3, 1921, and that death occurred, on the date stated above, at 6 N m.

The CAUSE OF DEATH* was as follows:

Cholangitis

(Duration) yrs. mos. 21 ds

Contributory (SECONDARY) Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

(Signed) Standish McAlister M. D.

Sept 3. 1921 (Address) 1609 Linden ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western Cemetery

DATE OF BURIAL: Sept 5, 1921

20 UNDERTAKER: W. M. Rowlson

ADDRESS: 2301 N Gilmor

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56685

CERTIFICATE OF DEATH.

43 D 56685

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1821 Rutland Ave. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Reeder

(a) RESIDENCE NO. 1821 Rutland Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Emma Reeder

6 DATE OF BIRTH (month, day, and year): July 19 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer): Lace ret.

(c) Name of employer: H. J. Firm

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Reeder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Josephine Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Emma Reeder
(Address): 1821 Rutland Ave

15 Filed SEP 5 - 1919 MORRIS I KRAUTER Registrar
Burial Permit Issued

CAUSE OF DEATH (See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 3 1919

I HEREBY CERTIFY, That I attended deceased from November 1 19 to September 3 19

that I last saw him alive on September 3 1919

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Epithelioma of left Cheek

(duration) 1 yrs. 10 mos ds.

CONTRIBUTORY (Secondary) General Carcinoma Glands

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 19

Was there an autopsy? No (Mcd Sond. Yes)

What tests confirmed diagnosis? Clinical

(Signed) Wallace A. Mcgehee M. D.

Sept. 5, 1919 Address 1011 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Sept 5 1919
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay St

Huffer.

Type — 6-9-19 — H. P. Co. — 1000 Bks.

D 56686

HEALTH DEPARTMENT—CITY OF BALTIMORE

+41 ✓

D 56686

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph D. Huffer.

(a) RESIDENCE. NO. Burkittsville, Fred'k County, Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Huffer

6 DATE OF BIRTH (month, day, and year) Jan. 31 1834.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87.	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Huffer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Mullendore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

11 Informant N. D. Huffer

(Address) 1527 N. Fulton Ave

12 SEP 5 - 1921 MORRIS S. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 29 1921. to Sept 4. 1921.

that I last saw h[illegible] alive on Sept 4 1921.

and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Annular carcinoma of the hepatic flexure of colon.

(duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of Aug 30 21

Was there an autopsy? no.

What test confirmed diagnosis? Exploratory laparotomy

(Signed) D. D. Smagner, M. D.

, 19 (Address) Mercy Hospital)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md	Sept 6 1921
20 UNDERTAKER Wm J Tuckwell Sons	ADDRESS North St

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. See reverse side for additional space. TION is very important. See instructions on back of certificates.

D 56687.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 D 56687.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2809 Walbrook ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Schetlick

(Residence in Baltimore: No. 2809 Walbrook Ave ST.: 42 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug 4, 1879
(Month) (Day) (Year)

7-AGE, 42 yrs. 0 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry Schetlick

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Pauline Hutschek

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs F Klostan

(Address) 709 Walbrook

15- ROBERT J. KRAUTER

Filed SEP 5 - 1921 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Bichloride of Mercury

(Duration) (a few hours) yrs. mos.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Sept 4 1921 (Address) 2802 E Lanvale Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Sept 7 1921

20-UNDERTAKER W F Tasmi & Son

ADDRESS 1201 W Lex St

CAUSE OF DEATH to be plainly written. Every item important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 56688

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 56688

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) No. 2409 Lake View Ave (3 WARD)

2-FULL NAME Florence H. Price.

(a) RESIDENCE. No. 2409 Lake View St. One WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widow of Frank Price

6 DATE OF BIRTH (month, day, and year) Sept. 9/1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63.	11	24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Aaron Herman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hanna Egger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Edward Price
(Address) 2409 Lake View

15 [illegible] 19 SEP 5 - 1921 Registrar [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1921, to Sept 2, 1921.

that I last saw h.. alive on Sept 2, 1921.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cachexia & Myocardial insufficiency. Following carcinoma of bladder.

(duration) 2. yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? cystoscopic exam.

(Signed) H. C. Marvel, M. D.

, 19 (Address) 3311 Abell Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Sept 5 1921

20 UNDERTAKER Josiah Syfer. ADDRESS 1600 W. North ave

IMPORTANT: See instructions on back of certificates. ATION is very important.

D 56689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1842 D 56689
REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1640 Clarkson St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estelle G. Lannatewitz.

(Residence in Baltimore: No. 1640 Clarkson St.

15 -------- St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White,	Married.

6-DATE OF BIRTH, October, 26th. 1886., 1
(Month) (Day) (Year)

7-AGE, 34 yrs. 10 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Chestertown, Md.

PARENTS.

10-NAME OF FATHER. Daniel B. Neall.

11-BIRTHPLACE OF FATHER (State or Country). Chestertown, Md.

12-MAIDEN NAME OF MOTHER Rachael Allston.

13-BIRTHPLACE OF MOTHER (State or Country). Chestertown, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry P. Lannatewitz. (husband)

(Address) 1640 Clarkson St.

15- SEP 5 - 1921 [illegible]
Filed..... 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 1st. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis.
due to abortion performed by self
Myocardial Insufficiency.

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.
(Coroner.)

Sept. 3., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Sept. 5th. 1921

20-UNDERTAKER F. B. Kippert

ADDRESS 2316 Frederick Ave

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Heliowicz

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 56690

D 56690

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 242 S. Wolfe St.: V Ward)

2-FULL NAME Rosalia Heliowicz

(a) RESIDENCE. No. 242 S. Wolfe St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3 1921

7 AGE — Years — Months 2 Days. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Heliowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Margerit Wladarczyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Louis Heliowicz 242 S Wolfe

15 Filed SEP 5 - 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1921, to Sept 5, 1921, that I last saw h... alive on Sept 4, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) William [illegible] M. D.

19 (Address) 8012 Eastwood

Sept 5 21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Sep 5 1921

DATE OF BURIAL

28 UNDERTAKER: John M. Weber

ADDRESS: 1803 Bank St

CAUSE OF DEATH TION is very important. See instructions on back of certificate.

Spec.--1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56691

CERTIFICATE OF DEATH.

91 D 56691

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3425 First Ave ST., 26 WARD)

2-FULL NAME Katherine M. Feller

(a) RESIDENCE NO. 3425 First Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Feller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Katherine Kenard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant John Feller
(Address) 3425 First Ave

15 Filed SEP 5 - 1921 ROBERT J. BRAUTIGAM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 3, 1921,

that I last saw her alive on Sept 3, 1921,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bromwell M. D.

9-4, 1921 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL Sept 5 1921

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Wood St

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify AS ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

D 56692

HEALTH DEPARTMENT—CITY OF BALTIMORE

103 D 56692

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 522 Holtzman Ct. WARD) (If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Wilhelmina Hammer

(Residence in Baltimore: No. 522 Holtzman St.; yrs. 5 mos. yrs. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, June (Month) 6 (Day), 1852 (Year)

7-AGE: 69 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

037

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: John Krieger

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (State or Country): Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Hammer

(Address) 522 Holtzman Court

15- SEP 5 1921 191... ROBERT P. KRAUTER REGISTRAR. Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Gastritis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(Duration) 3 yrs. ... mos. ... ds.

(Signed) G. A. Gladis M. D.
(Coroner)

Sept 2 1921 (Address) 143 N. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
St. Evangelical Cem	Sept 5, 1921
20-UNDERTAKER: H. Sauder & Son	ADDRESS: 1700 Red St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56693 — 191 V — D 56693

REGISTERED NO.

D 56693
1-PLACE OF DEATH

CITY OF BALTIMORE: (NO) St. Agnes Hospital (ST.) 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Doherty

(a) RESIDENCE. NO. Woodbine Md. ST. Grey WARD. Mt Airy
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edw Doherty 845

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 76 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Notary
(b) General nature of industry, business, or establishment in which employed (or employer): Odd
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Mahanoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant (Address): Sergeant E. Doherty Woodbine Md

15 Filed SEP 5 - 1921 Receipt 1 (illegible) Register

Burial (illegible) Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 21

17 I HEREBY CERTIFY, That I attended deceased from 8-24, 1921, to 9-4, 1921, that I last saw h[illegible] alive on 9-4, 1921, and that death occurred, on the date stated above, at 9 10 a.m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis.
(Senility.)
Bronchial pneumonia
(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary): Pulmonary edema
(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) St. Vagues Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Poplar Springs Md — DATE OF BURIAL: 9/6/21

20 UNDERTAKER: Geo A Farley Sykesville Md — ADDRESS

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

D 56694

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 V D 56694

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 38 Frost Hospital 3 WARD)

2-FULL NAME Clarence Jones

(Residence in Baltimore: No. 246 N. Dallas St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.) abt 1½ year.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Col.	Sgl

6-DATE OF BIRTH, ... (Month) ..... (Day) ....1..... (Year)

7-AGE. 21 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Va

PARENTS.

10-NAME OF FATHER, John Jones

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Jones

(Address) Va

15- Filed SEP 5 - 1921 19... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept 2 ....., 19V...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide by Pistol

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner)

S. D., ..., 192.., (Address) ..... St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Suffolk Va — DATE OF BURIAL, Sept. 5, 1921

20-UNDERTAKER John W Henderson & Monument — ADDRESS 1502

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56695

CERTIFICATE OF DEATH.

+/7 D 56695

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virgie Grey.

(a) RESIDENCE. NO. Elkridge Inf ST., WARD. Elkridge Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

(Single, Married, Widowed, or Divorced (write the word)): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE: 25 — Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Elkridge Md

PARENTS

10 NAME OF FATHER: Jas Grey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Elkridge Md

12 MAIDEN NAME OF MOTHER: Sallie Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Md.

14 Informant: Univ Hosp nurses (Address)

15 Filed SEP 5 - 1921 ROBERT J. KRAUTER Registrar

Recist record Elect

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to Sept 4, 1921, that I last saw h[illegible] alive on Sept 3, 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Septicaemia. Staphylococcus

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Pernephritis chron

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Elkridge Md

Did an operation precede death? Yes Date of July 15, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Physical & Laboratory

(Signed) [illegible], M. D.

Sept. 5, 1921 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Augustine Cem — DATE OF BURIAL: Sept 7 1921

20 UNDERTAKER: Easton Sons — ADDRESS: Ellicott City

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56696

CERTIFICATE OF DEATH.

151 ✓ D 56696

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2007 N. Washington ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Infant) Evelyn Bell Willis

(Residence in Baltimore: No. 2007 N. Washington St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 29, 1921, (Month) (Day) (Year) 1921.

7-AGE, ...yrs....mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, E. B. Willis

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Evelyn B Ahren

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. James Ahren

(Address) 2007 N. Washington St.

15- SEP 5 - 1921 Filed ....., 191.....

ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 4, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1921, to Sept 4 1921, that I saw her alive on Sept 4 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Premature Birth —
6½ months —
(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Malnutrition
(Duration) ....yrs. ....mos. ....ds.

(Signed) Elmer Gill Hale M. D.

Sept 5, 1921. (Address) 1617 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Parkwood Cemetery

DATE OF BURIAL, 9/5, 1921.

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X107 D 56697

REGISTERED NO.

D 56697

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. St.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from to that I last saw h alive on and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

SEP 5 - 1921

Registrar

56698 HEALTH DEPARTMENT—CITY OF BALTIMORE 63-001 56698

D 56698 CERTIFICATE OF DEATH. D 56698

1 PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE (No. Hospital, Hospital ST.: V WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 8.)

2 FULL NAME Loretta Kegler

(Residence in Baltimore: No. Hopkins Hospital St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Baby

6-DATE OF BIRTH, June (Month) (Day) 1919 (Year)

7-AGE, 2 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Thomas Kegler

11-BIRTHPLACE OF FATHER (State or Country) Hanover Md.

12-MAIDEN NAME OF MOTHER Constance Hays

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Kegler

(Address) 19 S. Washington St.

15- FILED SEP 5 1921 ROBERT J. CRAUTER Registrar. Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular
probably Pulmonary Edema
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. Ross Snively M. D.
(Coroner.)
Sept. 4, 1921 (Address) 406 Equitable Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence 198 Washington

19-PLACE OF BURIAL OR REMOVAL, Southern Cem. DATE OF BURIAL, Sept 6 1921

20-UNDERTAKER Austin Raley & Son ADDRESS 527 W North ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

56699 HEALTH DEPARTMENT—CITY OF BALTIMORE 56699

56699 CERTIFICATE OF DEATH. 104 D 56699

D 56699 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 St. Vincent Ally St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Beefelt

(a) RESIDENCE. NO. 1 St Vincent Ally St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 30 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Oliver Beefelt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) —

14 Informant St Vincent Ally
(Address) 1501 Dunmore

15 Filed SEP 5 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1921, to Sept 2, 1921, that I last saw her alive on Sept 2, 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) 3 ds.

CONTRIBUTORY (Secondary) Heart Prostration

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laparotomy

(Signed) Chas Adelmeier M. D.

Sept 2 1921 (Address) 1501 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Sept 6 1921

20 UNDERTAKER Martin Fuchs & Bro. ADDRESS 1823 N North

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. TION is very important. See instructions on back of certificates.

56700 HEALTH DEPARTMENT—CITY OF BALTIMORE 17-053 56700

D 56700 CERTIFICATE OF DEATH. D 56700

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE (No. Mt. Gen. Hop. St.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Jones

(Residence in Baltimore: No. 1048 Pennsylvania Ave St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec. 31, 1915
(Month) (Day) (Year)

7-AGE, 5 yrs. 9 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ump
(b) General nature of industry, business, or establishment in which employed (or employer) 0.0.

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Robt. Winn

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Jones

13-BIRTHPLACE OF MOTHER (State or Country), N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jones

(Address) 1048 Penna. Ave,

15- Filed SEP 5 1921, 191.... ROBERT I. BRAUTEN Registrar.

CAUSE OF DEATH to print items, important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 4, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and from Gwash find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rail Road Accident
R. arm & left foot amputated

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Sept 5, 1921 (Address) 2822 Eastern Ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Mt. Gen. Hosp in the of denth yrs. mos. 2 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? Springdale & Western Md. R.R.

Former or usual residence 1048 Pennsylvania Ave.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn (Cem) DATE OF BURIAL, Sept 6, 1921

20-UNDERTAKER Jas. Jr. Skinner ADDRESS 1625 E. Mad st.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

42

D 56701

D 56701

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1930 Edmondson ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Eoale

(a) RESIDENCE. NO. 1930 Edmondson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James M Eoale

6 DATE OF BIRTH (month, day, and year) Apr 13th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Abraham Winters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amanda Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant James M. Coale
Address 1930 Edmondson

15 [illegible] 19 SEP 6 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st 1919, to Sept 3rd 1921, that I last saw h[illegible] alive on Sept 1st 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Metastasis to Kidney

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 2d 1919

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Benj. Veader, M. D.

, 19 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Sept	6 — 1921
20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson ave

CAUSE OF DEATH in plain terms, so that it may be classified. See back of certificates. TION is very important. See instructions on back

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 56702

D 56702

HEALTH DEPARTMENT—CITY OF BALTIMORE

63-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 Chauncey ave ST.: 13 WARD)

2-FULL NAME Sylvan Thomas Abrams

(a) RESIDENCE. NO. 811 Chauncey ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -1

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jack Abrams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Della Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant N Abrams
(Address) 811 Chauncey ave

15 Filed SEP 6 1921 MORRIS A. KELLER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 5 1921

17 I HEREBY CERTIFY, That I attended deceased from 5 September, 1921, to 5 September, 1921, that I last saw him alive on 5 September, 1921, and that death occurred, on the date stated above, at 10.35 p m.

The CAUSE OF DEATH* was as follows:

Ante anterior poliomyelitis

(duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Gilbert W. Rosenthal, M. D.

6 Sep. 1921 (Address) 2227 Linden Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wakeman Rosenthal DATE OF BURIAL Sept 6 1921

20 UNDERTAKER Mark Flessner ADDRESS 817 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. Information is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56703

CERTIFICATE OF DEATH.

64 D 56703

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1518 E. Chase ST.: 8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Cordray.

(a) RESIDENCE. NO. 1518 E. Chase ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26/1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Floor Manager Silk Dept.

(b) General nature of industry, business, or establishment in which employed (or employer) Hoschild & Kohn

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Cordray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Mary Harrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mary C. Cordray (Address) 1518 E. Chase St

15 Filed SEP 6 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 21

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1920, to Sept 3, 1921, that I last saw him alive on Sept 3, 1921, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Myocarditis & Chr Interstitial Nephritis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Hoschild & Kohns Store

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination.

(Signed) William C. Keagle, M. D.

19 (Address) 203 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 6 1921
20 UNDERTAKER	ADDRESS
Frank A. Fink	916 N. Gay

Burial Permit Clerk

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56704 ✓ D 56704

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Kath. Schoen

(a) RESIDENCE. NO. 1232 Aisquith St. ST.: Eden St WARD:

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not Know

14 (Informant) Mrs Emily Schoen (Address) 1232 Aisquith St

15 Filed SEP 6 - 1921 ROBERT J. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 4 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-20, 1921, to 9-4, 1921, that I last saw h[illegible] alive on 9-4, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) appoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuels Cem	Sept 6 19
20 UNDERTAKER Louis Heuman	ADDRESS 32 S. Broadway

Burial Permit Clerk W 1948

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. Information required is for the use of the Health Department and not for publication. Do not write in the space below. Use ink. Write plainly. Do not use abbreviations. Do not use ditto marks. Be sure and answer every question. Do not write in the margin. Do not fold. Do not roll. Do not use pencil. Do not write on back of certificates. Do not write in the space below. Use ink. Write plainly. Do not use abbreviations. Do not use ditto marks. Be sure and answer every question. Do not write in the margin. Do not fold. Do not roll. Do not use pencil. Do not write on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Schlanvoght

D 56705 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 56705

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Bay View Hosp ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schlanvoght

(a) RESIDENCE. NO. 1704 Cole ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Dec 22 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66 yrs.	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Bay View Hospital Records

15 Filed SEP 6 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5th 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1920, to Sept 5, 1921, that I last saw her alive on Sept 5, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Epithelioma of Ear

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. C. Wilson M. D.

. 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 6 1921

20 UNDERTAKER MR. & MRS. N. S. FINK, FUNERAL DIRECTORS 1636 W. PRATT STREET. ADDRESS

CAUSE OF DEATH to be filled in plainly with ink or indelible pencil. Do not use abbreviations or ditto marks. Be particular and answer each question fully. Do not leave any blanks. Read carefully the instructions on back of certificates. ATTENTION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56706

154 D 56706

D 56706

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. #1424 Linden Ave., ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DANIEL BIXLER Jr.

(a) RESIDENCE. NO. #1424 LINDEN AVE. ST., 14 WARD. (Resident)

(Usual place of abode) (If nonresident give city town and State)

Length of residence in city or town where death occurred 87 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? 87 yrs. 2 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of (NONE.)

6 DATE OF BIRTH (month, day, and year) June-19-1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work RETIRED.

(b) General nature of industry, business, or establishment in which employed (or employer) RETIRED.

(c) Name of employer RETIRED.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Daniel Bixler

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Harriet Law

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Dr.W.H.H.Bixler,(nephew)
(Address) Baltimore,Md.

15 Filed SEP 6 - 1921 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1921

17 I HEREBY CERTIFY, That I attended deceased from 10 years ago 19.. to Sept 4 1921.

that I last saw him alive on Sept 4 1921.

and that death occurred, on the date stated above, at 1.15-P m.

The CAUSE OF DEATH* was as follows:

Senile debility

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bamford Cather, M. D.

19 (Address) 1404 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt.Olivet Cemetery. DATE OF BURIAL: Sep-6-21 19

20 UNDERTAKER: Stewart-Mowen Co.(W.F.Wooden) ADDRESS 108-W. North

CAUTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Frick

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56707

D 56707

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Hartford Av ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna J. Frick

(a) RESIDENCE. NO. 1010 Hartford Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Frick

6 DATE OF BIRTH (month, day, and year) Oct 11 75

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Fred Frick
(Address) 1010 Hartford

15 Filed SEP 6 - 1921 19.. ROBERT J. [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1 1924 to Sept 2 1924

that I last saw h.. alive on Sept 2 1924.

and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Lung
Tuberculosis Bowels

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Curtis M. D.

(Address) 1010 Hartford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	9/6/24
20 UNDERTAKER	ADDRESS
Edmund Conklin	924 E Eager

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56708

CERTIFICATE OF DEATH.

109 D 56708

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Patapsco ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hess

(a) RESIDENCE. NO. 1716 Patapsco ST., 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) Katherine Heinlein

6 DATE OF BIRTH (month, day, and year) ? ? 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	#	#	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Hess
(Address) 1716 Patapsco St

15 Filed SEP 6 - 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1921, to Sept 3, 1921, that I last saw him alive on Sept 3, 1921, and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

Complete Torsion of Intestines occluded Entirely (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gen Depression Myocardial (duration) yrs. mos. 24 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S J Turlington, M. D.

9,5 1921 (Address) 102 E 30th St Apt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross, Brooklyn	9/6/21 19
20 UNDERTAKER John J Fahey & Sons	ADDRESS 1318 Light St

CAUSE OF DEATH to be plainly written. Spaces must be filled with words and figures, not with ditto marks. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56709 D 56709

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1104 Vincent St. 16 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kathleen Mitchell

(Residence in Baltimore: No. 1106 Vincent St.; 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, August 3, 1858
(Month) (Day) (Year)

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ~~John Healy~~ Daniel Sisco

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Mahoney

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Mahoney

(Address) 1147 Whitelock St

15-

Filed SEP 6 1921 ROBERT J. [illegible] Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypertrophy heart disease

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia

(Duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy M. D.
(Coroner.)

Sept. 4, 1921 (Address) 2802 E. Hanson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery — DATE OF BURIAL, Sept. 7 1921

20-UNDERTAKER, James H. Deckard — ADDRESS 2013 Greenmount

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Silate

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56710 ✓ 52 D 56710

D 56710

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1622 Jackson ST.: 24 WARD)

2-FULL NAME Mary Louise Silate

(a) RESIDENCE. No. 1622 Jackson ST., WARD. 24

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Silate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Smuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George Silate

(Address) 1622 Jackson St

15 Filed ..... 19 ..... Registrar

SEP 6 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 5 1921, to Sept 5 1921, that I last saw her alive on Sept 5 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Asphyxia due to prolapsed umbilical cord 0

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Delayed Labor

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Sept 6, 1921 (Address) 1535 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	Sept 6 1921
20 UNDERTAKER J. Wm J. & E. Davis Sons a.a. Co.	ADDRESS 1428 Lbch

CAUSE OF DEATH in plain terms. Do not use abbreviations or initials. Name of disease alone not sufficient. Fill in all blanks. Use ink. Write plainly. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56711

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56711

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 N Lanvale ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Jones

(a) RESIDENCE. NO. 216 N Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie Poole Jones

6 DATE OF BIRTH (month, day, and year) Feb. 9 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Libertytown Frederick Co. Md.

PARENTS

10 NAME OF FATHER Francis S Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Margaret Gaither Jones 216 N Lanvale St

15 Filed SEP 6 - 1921 Burial Permit Issued Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/28, 1921, to 9/3, 1921, that I last saw him alive on 9/0 1921, and that death occurred, on the date stated above, at 5.50 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Broncheal - probably was many yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) M D Shubert, M. D.

9/5, 1921 (Address) 1008 Cathedral st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Sept 6 1921

20 UNDERTAKER John O Mitchell — ADDRESS 1201 W Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56712 — 170 — D 56712

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1625 Linden Ave. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Brewer.

(a) RESIDENCE. NO. 1625 Linden Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Brewer.

6 DATE OF BIRTH (month, day, and year): Dec 18, 1850

7 AGE — Years: 70 — Months: 8 — Days: 18. — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired Broker.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cumberland Md

PARENTS

10 NAME OF FATHER: John Brewer.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Md.

12 MAIDEN NAME OF MOTHER: Mary VanLear

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hagerstown Md.

14 Informant (Address): Anna Brewer. 1625 Linden ave.

15 [illegible] SEP 6 1921 ROBERT J. [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19 1921, to September 5. 1921, that I last saw him alive on September 4 1921, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis.

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic diffuse Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Chas Wilbur Stewart. M. D.

9/6, 1921 (Address) 1738 E. 28th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Sep 7 1921

20 UNDERTAKER: John O. Mitchell — ADDRESS: 120 W. Fayette

CAUSE OF DEATH on this page, and instructions on back of certificates. TION is very important. See instructions on back of cer

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56713

D 56713

55

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3118 N. Calvert ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richmond Virginia Campbell

(a) RESIDENCE No. 3118 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of E. N. Campbell

6 DATE OF BIRTH (month, day, and year) July 2, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Chesapeake City (State or country) Md

PARENTS

10 NAME OF FATHER Richard Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rebecca Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant E. N. Campbell (Address) 3118 N. Calvert St

15 Filed SEP 6 - 1921 ROBERT A. [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1921, to Sept 3, 1921, that I last saw her alive on Sept 3, 1921, and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Purpura haemorrhagica

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, High tension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr Chr Deetjen, M. D.

19 (Address) 1702 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Sept 6 1921

20 UNDERTAKER H. Sanders Sons — ADDRESS 1710 Fleet St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Gimmeman ✓

D 56714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56714

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3757 Elm Ave ST.; 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geraldine Gimmeman

(Residence in Baltimore: No. 3757 Elm Ave St.; 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June 16 (Month) (Day), 1921 (Year)

7-AGE, ...yrs. 2 mos. 17 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Walter E. Gimmeman

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER, Mildred Richards

13-BIRTHPLACE OF MOTHER (State or Country), Balto. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter E. Gimmeman

(Address) 3751 Elm Ave

15- Filed SEP 6 1921, 191.... ROBERT J. BRAUTER Registrar

Burial or Removal Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 31 1921, to Sept 5th 1921, that I saw h.r alive on Sept 5 1921, and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Enteritis - Colitis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. 2 mos. ....ds.

(Signed) D. R. Wantz M. D.

Sept 6, 1921 (Address) 2665 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Druid Ridge — DATE OF BURIAL, Sept 7, 1921

20-UNDERTAKER H. H. Marshall — ADDRESS 353 Fallsway

important. See instructions on back of certificate.

Spec.—6-9-19—B. P. Co.—1000 Bks.

Mary 6 Cuneo

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56715 ✓

D 56715

CERTIFICATE OF DEATH.

REGISTERED NO. 1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Eastern Ave ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Clara Cuneo

(a) RESIDENCE. NO. 919 Eastern ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of - John B. Cuneo

6 DATE OF BIRTH (month, day, and year) Unknown. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Reddadata

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mr. Henry Cuneo
(Address) 919 Eastern Ave.

15 Filed SEP 6 1921 16 Registrar ROBERT S. BRUTEN Registrar Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 18(18) 21. to Sept 4 1921.
that I last saw h alive on Sept 3 1921,
and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. Wedenburn M. D.

1924 (Address) 1112 n Bentz

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Sept 7, 1921
20 UNDERTAKER J. J. Cowan & Son	ADDRESS 901 Hollins St

CAUSE OF DEATH in plain terms, stating whether disease, injury, or violence. See instructions on back of certificate.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56716

CERTIFICATE OF DEATH.

D 56716

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 516 Bloom ST.: 14th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Woodrow Gassaway

(a) RESIDENCE. NO. 516 Bloom ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Elizabeth Gassaway

6 DATE OF BIRTH (month, day, and year) Jan 13, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ex. Butler 670

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unable to work for 2 mos.

9 BIRTHPLACE (city or town) (State or country) Baltimore City.

PARENTS

10 NAME OF FATHER Joshua Gassaway

11 BIRTHPLACE OF FATHER (city or town) Bates Rd (State or country)

12 MAIDEN NAME OF MOTHER Maria O'Neil

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co (State or country)

14 Informant Mary Elizabeth Gassaway (Address) 516 Bloom st

15 Filed ... 19 ... Registrar

SEP 6 - 1921 ROBERT J. [illegible]

Burial ... [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1921

17 I HEREBY CERTIFY, That I attended deceased from June 21, 19 21, to Sept 3, 19 21, that I last saw h alive on Sept 3, 19 ..., and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. 2 mos. 13 ds.

CONTRIBUTORY (Secondary) Artero Sclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 516 Bloom St

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Signed Symptoms

(Signed) ... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 7 1921
20 UNDERTAKER	ADDRESS
J. L. Browning Co	708 W Mont'y

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 56717

D 56717

CERTIFICATE OF DEATH.

64 65

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2254 Madison Avenue ST., 13 WARD)

2-FULL NAME Michael Morganstein

(a) RESIDENCE NO. 2254 Madison Avenue ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 20 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie Morganstein

6 DATE OF BIRTH (month, day, and year) [illegible] 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Known

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J Lewis
(Address) 1411 E Baltimore St

15 SEP 6 1921 ROBERT J KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20th, 1921, to Sept. 5th, 1921, that I last saw h... alive on Sept. 4th, 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Cerebral Softening
Exhaustion

(duration) ? yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? 2254 Mad. Ave

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Harry Goldberg M. D.

9/6 1921 (Address) 210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rekrem Rosedale — DATE OF BURIAL 9/6 1921

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Lack of certificates. TION is very important. See instructions on back of

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history

Spec.—8-24-14—M. & T.—2000 Bks.

15 D 56718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56718

CERTIFICATE OF DEATH.

[redacted]

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby. (Boy) Smith

(Residence in Baltimore: No. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	

6-DATE OF BIRTH, September 11, 1921
(Month) (Day) (Year)

7-AGE, ...yrs...mos...ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Paul B Smith

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Kate Rosenberg

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records

(Address)

15- SEP 6 - 1921 ROBERT J. [illegible]
Filed ..., 191... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ...191..., to ...191...,
that I saw him alive on Sept. 11, 1921,
and that death occurred, on the date stated above, at 10:30 P m.
The CAUSE OF DEATH* was as follows:
Asphyxia Neonatorum
Type Pellida
... (Duration)...yrs...mos...ds.

CONTRIBUTORY (Secondary)
Prematurity (Duration)...yrs...mos...ds.

(Signed) Albert Jaffe M. D.
Sept 5, 1921. (Address) No. Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale DATE OF BURIAL, 9/6/21 191...

20-UNDERTAKER Jack Lewis ADDRESS 1411 S Bdwy

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D 56719 — 37 D 56719

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter McDonough

(a) RESIDENCE. NO. Bay View ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inmate

(b) General nature of industry, business, or establishment in which employed (or employer) Bay View

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record
(Address) New City Hospital

15 Filed SEP 6 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1921

17 I HEREBY CERTIFY, That I attended deceased from 7-1- 1915 to 8-31 1921 that I last saw h. alive on 8-31 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Aneurysm of aorta Over

(duration 3 yrs. mos. ds.)

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

(Address) New City Hop.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	9/6 1921

20 UNDERTAKER Edward F. Evans & Son ADDRESS 1180 W. Fayette

CAUSE OF DEATH in plain English. [illegible] TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to
luetic infection

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

110 D 56720

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Union Memorial Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Leon Seligman

(a) RESIDENCE. No 3414 Auchentoshly Terrace ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mrs. Maurice H. Seligman

6 DATE OF BIRTH (month, day, and year) Oct. 2, 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Benzeiner Bros.

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Meyer Seligman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elise Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Maurice H. Seligman (Address) 3414 Auchentoshly Terrace

15 Filed SEP 6 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1921, to Sept 5, 1921, that I last saw him alive on Sept 5, 1921, and that death occurred, on the date stated above, at 2:25 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) ~~yrs~~ ~~mos~~ 4 ds.

CONTRIBUTORY (Secondary) (Aspiration) Bronchopneumonia

(duration) ~~yrs~~ ~~mos~~ 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Sept. 4. 1921

Was there an autopsy? Yes - partial.

What test confirmed diagnosis?

(Signed) Edward M. Hanrahan Jr., M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chev Sholam Cem. DATE OF BURIAL 9/7 1921

20 UNDERTAKER David Sondheim ADDRESS 118 W. Mt Royal Ave

CAUSE OF DEATH to be plainly written, so that it can be understood by any one reading it. See instructions on back of certificates. THIS is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Exploratory operation to determine the cause of Peritonitis found Diverticulitis

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56721

CERTIFICATE OF DEATH.

19 D 56721

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1242 Edward ST.; 5 WARD)

2-FULL NAME Rebecca Stearns

(a) RESIDENCE. NO. 1242 Edward ST., 5 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Stearns

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James Stearns
(Address) 1242 Edward St.

15 Filed SEP 6 - 1921 ROBERT J. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4. 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17. 1921. to Sept 4. 1921. that I last saw h[illegible] alive on Sept 4. 1921. and that death occurred, on the date stated above, at 12-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green M. D.

9-5. 1924 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wakefield Va

DATE OF BURIAL Sept 6 1921

20 UNDERTAKER Chas G Bailey

ADDRESS 47 Jefferson St

CAUSE OF DEATH to be plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56722

CERTIFICATE OF DEATH.

39 D 56722

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2404 Greenmount. Ave. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James McDermott

(a) RESIDENCE. NO. 2404 Greenmount. Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Sanna. McDermott

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 66	--	--	

8 OCCUPATION OF DECEASED

086

(a) Trade, profession or particular kind of work Stable manager for

(b) General nature of industry, business, or establishment in which employed (or employer) American Express

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Owen McDermott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Sheehan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. P. McDermott
(Address) 2404 Greenmount Ave

15 Filed SEP 6 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5. 1921

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1921, to Sept 5, 1921, that I last saw him alive on Sept 5, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Mouth & Neck)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) W. W. Gaddes, M. D.

9/5, 1921 (Address) 32 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Sept. 7 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56723

CERTIFICATE OF DEATH.

40 D 56723

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2409 E. Jefferson St. St.: 6 Ward)

2-FULL NAME Mary. Clementine. Anderson.

(a) RESIDENCE. No. 2409 E. Jefferson St. St.. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of The late Nathaniel Anderson

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) San Francisco Cal.

PARENTS

10 NAME OF FATHER George Hoyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Eliza. Lutts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Mary Anderson
(Address) 2409 E. Jefferson St

15 Filed SEP 6 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5. 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921, to Sept. 3 1921, that I last saw h[illegible] alive on Sept. 3 1921, and that death occurred, on the date stated above, at 10:29 A. M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) Edgar C. Faulkell M. D.

. 19 (Address) 15 West Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemy	Sept. 8 1921
20 UNDERTAKER	ADDRESS
Henry Hoerle Son	130, E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

D 56724

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56724

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 104 E. Gitting St. ST.: 24 WARD) 155

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Roe Jefferies.

(Residence in Baltimore: No. 104 E. Gitting St. St.: 55 yrs., 6 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, February 16th. 1866., 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
55 yrs. 6 mos. 18 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer in
(b) General nature of industry, business, or establishment in which employed (or employer): Ship yard.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Jefferies.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Elizabeth Schaefer.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlotta Jefferies, (wife)

(Address) 104 E. Gitting St.

15- FILED SEP 6 1921 191 ROBERT I. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 3rd. 1921., 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uraemia.
Due to Bichloride poisoning.
Suicide.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D. (Coroner.)

Sep. 6., 1921 (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem	9/6, 192
20-UNDERTAKER	ADDRESS
J. Frew McCully	130 E Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56725

CERTIFICATE OF DEATH.

D 56725

1-PLACE OF DEATH Johns Hopkins Hospital Phipps Clinic REGISTERED NO. C.....

CITY OF BALTIMORE: (No..... St.; W 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Fiedler

(Residence in Baltimore: No. Catonsville Md. Heights Ave St.; ..... yrs., 11 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, March (Month) 6 (Day), 1864 (Year)

7-AGE, 57 yrs. 6 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Gardener
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Joseph Fiedler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Gertrude Gerber

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Leslie B. Hohman

(Address)..... Johns Hopkins Hosp.

15- Robert P. Harrison,

Filed ....., 191.....

Registrar.

Burial Permit Clerk.

D 6 1921

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2nd 1921, to Sept 5 1921, that I saw him alive on Sept 5 1921, and that death occurred, on the date stated above, at 7.30 A.m.

The CAUSE OF DEATH* was as follows:

1. Tumor, left lung

.....

.....

..... unknown (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration)..... yrs..... mos. 1 ds.

(Signed) Leslie B. Hohman M. D.

Sept 5, 1921 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 3 ds. In the State 36 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Catonsville Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Mary's Cem.	Sept 6, 1921.
20-UNDERTAKER	ADDRESS
Eastern Sons	Elkton Md

Probably malignant. Refused autopsy as diagnosis indefinite. Not tuberculous

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

D 56726 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56726

45

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 191 N. Belnord ST., 6 WARD)

2-FULL NAME George F. Smith

(a) RESIDENCE NO. 191 N. Belnord Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Kate Smith

6 DATE OF BIRTH (month, day, and year) Mar 17 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer) for City.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Kate Smith (wife) (Address) 191 N. Belnord Ave.

15 Filed 9-6- 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept X 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 15, 19 21, to Sept X, 19 21.

that I last saw h[illegible] alive on Sept X, 19 21

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) ——— yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. L. Meyer Jr. M. D.

9/5/1921 (Address) 1638 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL 9/7 1921

20 UNDERTAKER John A. Moran ADDRESS 3000 E Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56727

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56727

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. PHS Hosp. #56.

CITY OF BALTIMORE: (NO. Fort McHenry Baltimore St. 40 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin F Parsons.

(a) RESIDENCE NO. US PHS Hosp. #56 Fort McHenry ST. Baltimo WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Benjamin F Parson.

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34 yrs.	--	-- -	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) West Virginia.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar.

(Address) US PHS Hosp. #56 Ft McHenry Md.

Filed 1921 Robert F. Harrison, .19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4, 19 21

17 I HEREBY CERTIFY, That I attended deceased from May 24, , 1921, to Sept. 4, , 19 21.

that I last saw him alive on Sept. 4, , 19 21,

and that death occurred, on the date stated above, at 8'20 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far. adv. active.

May 24, /21 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ---- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Clinic report.

(Signed) Thomas B. Payne, M. D.
Senior Surgeon (R)

9/4/. 19 21 (Address) US. PHS Hosp. #56 Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charleston W. Va

DATE OF BURIAL Sept 6 1921

20 UNDERTAKER Fol Simmons

ADDRESS USE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE or CONDITION is very important. See instructions on back of certificates.

FP 6

Spec.—6-0-19—H. P. Co.—1000 Bks.

D 56728

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56728

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 W Baltimore St.: 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Squires

(a) RESIDENCE. No. 1814 W Baltimore St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced (write the word)~~
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) 1840 April 11th

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	April		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabinet maker
(b) General nature of industry, business, or establishment in which employed (or employer) 014
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS
10 NAME OF FATHER Geo W Squires
11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)
12 MAIDEN NAME OF MOTHER Margaret Landgraf
13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Thomas C. Squires
(Address) 1814 W Baltimore St

15 Filed Robert P. Harrison, Registrar

SEP 6 - 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1921, to Sept 4, 1921, that I last saw him alive on Sept 4, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Organic Valvular disease of heart
(duration) 3 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) J. H. Hoffman M. D.
. 19 (Address) 180 N Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK	SEPT 7 1921
20 UNDERTAKER Robert Brokerson	ADDRESS 175 CALHOUN ST

CAUSE OF DEATH must be plainly stated. Use no abbreviations or terms. Indefinite terms, such as "Heart Failure," "Old Age," "Exhaustion," "Convulsions," "Cancer," "Tumor," "Abscess," "Child-bed," "Fever," "Inflammation," "Hemorrhage," "Accident," "Suicide," "Homicide," "Drowning," "Found Dead," "Burns," "Scalds," "Poisoning," "Blood Poisoning," "Septicemia," "Pyemia," "Uremia," "Meningitis," "Peritonitis," "Pneumonia," "Tuberculosis," "Consumption," "Asthma," "Bronchitis," "Diarrhoea," "Dysentery," "Cholera," "Cholera Infantum," "Marasmus," "Debility," "Senility," "Infancy," "Childhood," "Locomotor Ataxia," "Paralysis," "Epilepsy," "Apoplexy," "Hydrocephalus," "Spinal Disease," "Spinal Irritation," "Brain Disease," "Kidney Disease," "Liver Disease," "Stomach Disease," "Bowel Disease," "Womb Disease," "Childbirth," "Miscarriage," "Abortion," "Premature Birth," "Stillborn," "Still Born," "Congenital," "Malformation," "Malignant," "Gangrene," "Mortification," "Ulceration," "Inanition," "Want of Breast Milk," "Teething," "Lockjaw," "Cold," "Chill," "Fright," "Shock," "Sunstroke," "Weakness," "Natural Causes," "Unknown," "Not Known," "Not Ascertained," "Not Certified," "Not Given," "Not Stated," "Not Specified," "Not Known How," "Not Known Why," "Not Known Cause," "Not Known Nature," "Not Known Disease," "Not Known Illness," "Not Known Complaint," "Not Known Symptoms," "Not Known Duration," "Not Known Age," "Not Known Sex," "Not Known Color," "Not Known Race," "Not Known Birthplace," "Not Known Residence," "Not Known Occupation," "Not Known Parentage," "Not Known Maiden Name," "Not Known Informant," "Not Known Address," "Not Known Filed," "Not Known Registrar," "Not Known Burial Permit Clerk," "Not Known Undertaker," "Not Known Place of Burial," "Not Known Cremation," "Not Known Removal," "Not Known Date of Burial," "Not Known Address of Undertaker," "Not Known Date of Death," "Not Known Time of Death," "Not Known Place of Death," "Not Known Cause of Death," "Not Known Certificate of Death," "Not Known Medical Certificate of Death," "Not Known Personal and Statistical Particulars," "Not Known Parents," "Not Known Occupation of Deceased," "Not Known Age," "Not Known Years," "Not Known Months," "Not Known Days," "Not Known If LESS than 1 day," "Not Known hrs.," "Not Known or," "Not Known min.," "Not Known Sex," "Not Known Color or Race," "Not Known Single, Married, Widowed, or Divorced," "Not Known If married, widowed, or divorced," "Not Known Husband of," "Not Known Wife of," "Not Known Date of Birth," "Not Known Birthplace," "Not Known Name of Father," "Not Known Birthplace of Father," "Not Known Maiden Name of Mother," "Not Known Birthplace of Mother

Spec.—1-10-21—M&T—1500 Blks.

D 56729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56729

CERTIFICATE OF DEATH.

40

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 S. Fifth St. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Haunmelman.

(a) RESIDENCE NO. 803 S. Fifth St ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widow

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 20-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore city.

PARENTS

10 NAME OF FATHER Andrew Gensler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Elizabeth Haas.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Emma Haunmelman (Address) 803 S. Fifth St.

15 Filed SEP 6 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1921

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1921, to Sept 3, 1921, that I last saw her alive on Sept 3, 1921, and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Reifschneider, M. D.

9-5, 1921 (Address) 340 E. Eager Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL Sept 7 1921

20 UNDERTAKER Lilly & Zeile ADDRESS 403 S. Wolfe.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56730

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56730

CERTIFICATE OF DEATH.

X 105

REGISTERED NO.

1-PLACE OF DEATH St. Joseph's Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 9 St., 9 Ward)

2-FULL NAME Joseph August Griffith, Jr.

(a) RESIDENCE. NO. near Eastern Ave. St., Stemmers Run Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Magdalene Griffith

6 DATE OF BIRTH (month, day, and year) Aug. 8-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General natore of industry, business, or establishment in which employed (or employer) Standard Oil Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City.

PARENTS

10 NAME OF FATHER Joseph W. Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bath England.

12 MAIDEN NAME OF MOTHER Catherine Burk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City.

14 Informant (Address) Magdalene Griffith Stemmers Rn Rd.

15 Filed 19 Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921 to Sept 2, 1921.

that I last saw him alive on Sept 2, 1921.

and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Duodenal Ulcer

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Sept. 1, 1921

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. F. Fonte, Jr. M. D.

19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Sept. 6 1921.

20 UNDERTAKER Lilly & Zeller

ADDRESS 400 S. Hoff

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

SEP 6 1921

D 56731 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56731

56

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2503 W Baltimore ST. 27 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ferdinand A. Trobert

(Residence in Baltimore: No. Locust Ave Overlea St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 5th (Day), 1876 (Year)

7-AGE. 20 yrs. 2 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk 609
(b) General nature of Industry, business, or establishment in which employed (or employer) BROKN

9-BIRTHPLACE. (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Joseph J. Trobert

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Mary Ruth

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Trobert

(Address) Overlea Md

15-

Filed ....., 191.....

Robert F. Harrison, Registrar.

1321 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) find that said deceased came to h.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Convulsions

Uremia Nephritis Chronic

Jaundice 4 mos. (Duration) yrs. mos. ½ ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Cullen M. D. (Coroner)

Sept 14, 1921 (Address) 10 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem.	Sept 7, 1921
20-UNDERTAKER Lilly & Fiske	ADDRESS 403 S. Wolfe St

N.B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Not tuberculous. Five specimens examined. Carcinoma breast & only history that could be obtained from deceased was that he had

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage*,	*Meningitis*,	*Phlebitis*,
Cellulitis,	*Gangrene*,	*Miscarriage*,	*Pyæmia*,
Childbirth,	*Gastritis*,	*Necrosis*,	*Septicæmia*,
Convulsions,	*Erysipelas*,	*Peritonitis*,	*Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Falvey)

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 91
45,091 D 56732

D 56732

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Falvey

(a) RESIDENCE. No. Rickard Bro Baare St. Ramsay Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: about 60 years — Months — Days — about 60 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Not any.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant: Mr. John Shey
(Address) 510 Calhoun St

15 Filed 6 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-6 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-23, 1921, to 9-6, 1921, that I last saw him alive on 9-6, 1921, and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma prostate.
Metastases to lungs.

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary): Bronchial pneumonia

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopic

(Signed) Dudley P. Bowe, M. D.

. 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See ceverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters. DATE OF BURIAL: 9/7 — 1921

20 UNDERTAKER: Wm Coot ADDRESS: 501 E. North

CAUSE OF DEATH in plain terms, so that it may be properly coded. Do not use abbreviations or symptoms. See instructions on back of certificates. TION is very important.

Print.—6-9-19—H. P. Co.—1000 Bks.

D 56733

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56733

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Miller

(a) RESIDENCE. NO. 315 S. Caroline st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rimmer

(b) General nature of industry, business, or establishment in which employed (or employer): Shipyard

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Russia (?)

PARENTS

10 NAME OF FATHER: John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: ? Alexandria

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records

(Address) M.T.H.

15 Filed 9-6-1921

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 31, 1921, to Sept. 3, 1921, that I last saw him alive on Sept. 3, 1921, and that death occurred, on the date stated above, at 11.40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) Francis L. Dadaglacca M. D.

9-3-21. (Address) Municipal Tu Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	1921
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

(Scheibenzuber)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56734

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH New City Hosp.

CITY OF BALTIMORE: (No. ..... ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos. Scheibenzuber

(a) RESIDENCE. NO. 30 W Pratt ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-13-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 014

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Jos Scheibenzuber

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Hospital Records
(Address)

15 Filed SEP 6 - 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-1921

17 I HEREBY CERTIFY, That I attended deceased from 8-29, 1921, to 9-3-21, 19..., that I last saw him alive on 9-3-21, 1921, and that death occurred, on the date stated above, at 2:35 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Post

(Signed) Clyde McNeil, M. D.

9-6-21 (Address) New City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 6th 1921
20 UNDERTAKER	ADDRESS
Geo Leimbacher & Son	642 Pratt

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Triplett)

D 56735 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56735

100

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST.: 9 WARD) REGISTERED NO. C

2-FULL NAME Arthur P. Triplett

(Residence in Baltimore: No. 1333 4 Cumberland ave St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, June 23 (Month) 1914 (Day) (Year)

7-AGE, 7 yrs. 2 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, Page Triplett

11-BIRTHPLACE OF FATHER (State or Country). W. Va

12-MAIDEN NAME OF MOTHER Prudence Knight

13-BIRTHPLACE OF MOTHER (State or Country). W Va,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Page Triplett

(Address) 1333 4 Cumberland

15- Robert P Harrison

Filed ..... 191 ..... Burial Permit Clerk ..... Registrar.

26 - 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to L death on the day stated above.

The CAUSE OF DEATH* was as follows:

Embolism of Pulmonary Artery following Surgical operation under General Anesthesia 2nd Dental

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M Fenlon M. D. (Coroner.)

Sept 6, 1921 (Address) 700 E Chase St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 1333 4 Cumberland Md

Former or usual residence 1333 4 Cumberland Md

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Sept 7, 1921

20-UNDERTAKER Geo W Little — ADDRESS 2700 Edmondson Ave

*—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D 56736 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56736

CERTIFICATE OF DEATH. 120

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3546 Benson ST. 13 WARD)

2-FULL NAME Charles Hobbs

(a) RESIDENCE NO. 3546 Benson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 7 mos. 13 ds. How long in U. S., if of foreign birth? 76 yrs. 7 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) late Frances Hobbs.

6 DATE OF BIRTH (month, day, and year) Jan. 23 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	7.	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Fireman

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired 086

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown.

14 Informant Mary E. Fitzpatrick (Address) 3546 Benson St

15 Filed ....., 19 ..... Registrar Robert F. Harrison, Burial Permit Clerk.

P 6 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Sept 5th, 1921,

that I last saw h.. alive on Sept 4 1921

and that death occurred, on the date stated above, at 10 15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Chronic Myocarditis

Uremia (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) W. H. Smith, M. D.

, 1921 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 7 1921
20 UNDERTAKER Ensworth & Son.	ADDRESS 3617 Eastern Ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56737

D 56737

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 N. Mount ST.: 16 WARD)

2-FULL NAME William Thomas Gurry.

(a) RESIDENCE. No. 1010 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Gurry.

6 DATE OF BIRTH (month, day, and year) March 25-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Calvert Co, Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Minnie Gurry.
(Address) 1010 N. Mount St.

15 Filed ..... 19 ..... Registrar

SEP 7-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-4 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-2, 1921, to 9-4, 1921, that I last saw h.im alive on 9-3, 1921, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 9 mos. 20 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 1913 White St.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Chester Ruland., M. D.

9-4, 1921 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 6 21
20 UNDERTAKER	ADDRESS 916
Daniel Easter	Penna ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 56738

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 56738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 W Belvedere Av ST.; 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C Schamberger

(a) RESIDENCE. No. 226 W Belvedere av ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE: Years 72; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frederick Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Dario Schamberger
(Address) 226 Belvedere Ave

15 Filed ....., 19 ..... Registrar

SEP 7-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1921, to Sept 5, 1921, that I last saw him alive on Sept 4, 1921, and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Gen Debility

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) Charles J Wells, M. D.

, 19 (Address) 2 W Belvedere av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Sept 7 1921
20 UNDERTAKER	ADDRESS
Martin Fahrney & Sons	827 W Balto

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec. (-9-21)-R. P. Co.-1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56739

CERTIFICATE OF DEATH.

D 56739

REGISTERED NO. 43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Mathews Snead

(a) RESIDENCE. NO. 236 N. Paca St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 - 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Georgiana Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) John Hopkins Hospital

15 SEP 7 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 - 1921 to Sept 1 - 1921.

that I last saw her alive on Sept 1 - 1921.

and that death occurred, on the date stated above, at 5-10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast
Metastasis to pleura and liver.

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 25, 1921

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

9.4.21 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Denton Md	Sept 7th 1921

20 UNDERTAKER A. Jones

ADDRESS 207 S. Stricker St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56740 64 D 56740

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 E 25th ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Buckmaster Deale

(a) RESIDENCE. NO. 104 E 25th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 16-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harpers Ferry W. Va

PARENTS

10 NAME OF FATHER Rev. John S. Deale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Buckmaster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) John S. Deale Catonsville Md

15 Filed SEP 7 - 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1914 to Sept 5 1921, that I last saw her alive on Sept 5 1921, and that death occurred, on the date stated above, at 11.10 P m.

The CAUSE OF DEATH* was as follows:

Chronic hypertonitis with hypertension

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy (Hemiplegia)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert Winfield M. D.

Sept 6 1921 (Address) 711 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Green Mount Cem	Sep 8
20 UNDERTAKER	ADDRESS
John O. Mitchell	1701 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56741

D 56741

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH Nursery & Childs Hospital

CITY OF BALTIMORE: (No. Frankling & Schroeder ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Roberts

(a) RESIDENCE. NO. Nursery & Childs Hop ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed~~ or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Baby.

6 DATE OF BIRTH (month, day, and year): April 22-1920.

7 AGE — Years: 1 — Months: 4 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~Inf~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): John Hopkins Hosp.

PARENTS

10 NAME OF FATHER: Jesse Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kansas

12 MAIDEN NAME OF MOTHER: Eleanor Heinkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto-Md.

14 Informant: Mrs. Sarah Heinkel
(Address): 1907 Georgia Ave

15 Filed SEP 7-1921 19 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 6- 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15 . 1921 . to Sept. 6 . 1921 .
that I last saw her alive on Sept. 4 . 1921 .
and that death occurred, on the date stated above, at 6 a.m.
The CAUSE OF DEATH* was as follows:
Nutritional Decomposition

(duration) yrs. 3 mos. 22 ds.

CONTRIBUTORY (Secondary): Osteosis —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Heinkel M. D.

. 19 (Address) 1907 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 7, 1921

20 UNDERTAKER: George D. Smith — ADDRESS: 1000 Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Stumpfeley

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56742

CERTIFICATE OF DEATH.

15 V D 56742

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1743 E. 25th St. WARD 9)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Daughter of Mr. & Mrs. Stumpfeley

(a) RESIDENCE. No. 1743 E 25th St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1/2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 6 1921

7 AGE — Years — Months — Days — If LESS than 1 day 12 hrs. 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Geo. J. Stumpfeley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Geo. J. Stumpfeley

(Address): 1746 E. 25th St

15 Filed SEP 7 - 1921 . 19 ROBERT J. TRAUTEN Registrar

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1921, to Sept 6, 1921, that I last saw her alive on Sept 6, 1921, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

12 hrs (duration)

CONTRIBUTORY (Secondary) Cat Scratch (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. E. Rumbach M. D.

(Address) 1312 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Immanuels Cemetery — DATE OF BURIAL: Sept. 7 1921

20 UNDERTAKER: H. Sander & Sons — ADDRESS: 1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56743

CERTIFICATE OF DEATH.

151 D 56743

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 So. Spring ST.: 3 WARD)

2-FULL NAME Naomie Forshlager

(a) RESIDENCE. NO. 137 So. Spring ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 24. 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Michale Forshlager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sara Flenkman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Michael Forshlager
(Address) 137 S Spring St

15 Filed SEP 7 - 1921 19 [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 31st, 1921, to Aug. 31st, 1921, that I last saw her alive on Aug 31st, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Emil Snyder, M. D.

9/7, 1921 (Address) 38 So. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	9/7 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56744

CERTIFICATE OF DEATH.

104

D 56744

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 745 E. 30th St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Schneider

(a) RESIDENCE. NO. 745 E 30th St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8/1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis W. Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma Harms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Louis Schneider
(Address) 745 E. 30th

15 SEP 7 - 1921 ROBERT I. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 3rd, 1921, to Sept 6th, 1921, that I last saw h— alive on Sept 6th, 1921, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Sick.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What lesl confirmed diagnosis?

(Signed) Howard Wm D. M. D.

9/6 1921 (Address) 402 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Loudon Park — Sept 7 1921

20 UNDERTAKER — ADDRESS

Wm Cook 502 E Fayette

mation should be carefully reported. Any false statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56745 — 78 D 56745

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 626 W. Lee ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Marion Britton

(a) RESIDENCE. NO. 626 W. Lee St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 9. 1903

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	18	—	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Altoona, Penna

PARENTS

10 NAME OF FATHER Wm. Albert Britton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Shamokin, Penna

12 MAIDEN NAME OF MOTHER Bessie M. Thennen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Shamokin, Penna

14 Informant Mrs A. Britton
(Address) 626 W Lee St

15 Filed . 19
SEP 7-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 6 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28. 1921. to Aug. 6. 1921.
that I last saw her alive on Aug 6. 1921.
and that death occurred, on the date stated above, at 1.35 p. m.
The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion from heat

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? City Health Dept.

(Signed) P Bellson M. D.

9/6. 1921 (Address) 1124 W. Lafayette Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W Ox Oak Cemetery	Sep 9 1921
20 UNDERTAKER	ADDRESS
Wellman Co/c	502 E Mon

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 56746

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56746

105 V

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1 S Regidan ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Miller

(Residence in Baltimore: No. 1 S Regidan St.; 69 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1 (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country), born in Baltimore City

PARENTS.

10-NAME OF FATHER, Jane Miller

11-BIRTHPLACE OF FATHER (State or Country), St Marys Co. Md.

12-MAIDEN NAME OF MOTHER Jane Ring

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cattie White

(Address) 15 Redishler St

15- Filed SEP 7 - 1921 191.. ROBERT J KRAUTER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 27 1921, to Sept 5 1921, that I saw h.. alive on Sept 4 1921, and that death occurred, on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C B Britton M. D.

Sept 6, 1921. (Address) 1711 E Back St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetery

DATE OF BURIAL. Sept 7.., 1921

20-UNDERTAKER Mrs R A Elliott

ADDRESS 1723 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item important. See instructions on back of certificate.

D 56747

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56747

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1373 N. Calhoun St.; 15 WARD) Butler

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Eliz. [redacted]

(Residence in Baltimore: No. 1373 N. Calhoun St.; 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	widow

6-DATE OF BIRTH, ...March...., 1846
(Month) (Day) (Year)

7-AGE	If LESS than 1 day,
....75....yrs.....mos.....ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....housework....
(b) General nature of industry, business, or establishment in which employed (or employer) ....home....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Boyton

11-BIRTHPLACE OF FATHER (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Enthisan

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Bennett

(Address) 1373 N. Calhoun

15- SEP 7- 1921 CORONER'S INQUEST

Filed ..... 191.. [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...Sept....4....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....inquest.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....jury.... (Inquest, autopsy or inquiry.) found that said deceased came to .....death on the day stated above.

The CAUSE OF DEATH* was as follows:

....Cerebral Hemorrhage....

.....

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) ....Hypertrophy....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J. C. Heckman M. D.
(Coroner.)

Sept. 4 1921 (Address) 2802 Edgewood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Keller's Wharf-St Mary's Co. Md.	Sept. 7., 1921

20-UNDERTAKER James H. Dennis ADDRESS 1303 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56748

CERTIFICATE OF DEATH.

28 D 56748

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST.: Municipal Tuberculosis Hospital 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Myers

(a) RESIDENCE. No. 245 S. Caroline st. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Myers

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)..... (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Myers

11 BIRTHPLACE OF FATHER (city or town)..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Myers

13 BIRTHPLACE OF MOTHER (city or town)..... (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed SEP 7 - 1921 ROBERT J. TRAUTH Registrar

Burial Permit Oiet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3 1921 to Sept. 5 1921 that I last saw h im alive on Sept. 5 1921 and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis L. Badaglacca M. D.

9-5-21. (Address) Municipal T.B. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 5 1921
20 UNDERTAKER	ADDRESS
Wendel Hopper (for)	37 S. Howard St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 56749

D 56749
1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No 3131 Elliott ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orrion E. Speelman.

(a) RESIDENCE. NO. 3131 Elliott ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Philomena Speelman.

6 DATE OF BIRTH (month, day, and year) July 24-1856.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	1	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer 163
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer A. A. Chemical Co.

9 BIRTHPLACE (city or town) North Cumberland
(State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Speelman

11 BIRTHPLACE OF FATHER (city or town) North Cumberland
(State or country) Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not known

14 Informant Philomena Speelman
(Address) 3131 Elliott St.

15 Filed SEP 7 - 1921 BOARD OF HEALTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1921, to Sept 6, 1921, that I last saw him alive on Sept 6, 1921, and that death occurred, on the date stated above, at 3.45 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) H B Tutlow M. D.

9/6. 1921 (Address) 314 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cumberland, Md.	Sept. 9 1921
20 UNDERTAKER Zirkler + Zirkler	ADDRESS 1739 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT TION is very important. See instructions on back of certificates.

D 56750

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D 56750

REGISTERED No. C

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1901 E Lafayette ave ST. 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas F. Aburn

(Residence in Baltimore: No. 1901 E Lafayette Ave St.: yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH Mar 1 (Month), 1850 (Day) (Year)

7-AGE 70 yrs. 6 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Commission Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 043

9-BIRTHPLACE (State or country) City

PARENTS

10-NAME OF FATHER Austin B Aburn

11-BIRTHPLACE OF FATHER (State or country) City

12-MAIDEN NAME OF MOTHER Emily J Arnold

13-BIRTHPLACE OF MOTHER (State or country) City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary L Aburn

(Address) 1901 E Lafayette ave

15 Filed SEP 7-1921 ROBERT J. KRAUTER Vital Statistics Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 5 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 21, 191.., to Sept 4 191..

that I saw him alive on Sept. 4 191..

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. G. Peters M. D.

Sept 6, 1921 (Address) 1727 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Bulls Cemetery | DATE OF BURIAL Sep 8 1921

20-UNDERTAKER E J Fleming | ADDRESS 1908 E Lafayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 56751

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 W. Mulberry ST.; 18 WARD)

2-FULL NAME Anna Hoos

(a) RESIDENCE. No. 1203 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced
1 HUSBAND of (or) WIFE of Bernhard Decker
2 John Hoos

6 DATE OF BIRTH (month, day, and year) Jan 12 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hochdadt Bavaria Germany

PARENTS

10 NAME OF FATHER — Sitter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER — Ruff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Bernard F. Hoos
(Address) 1203 W. Mulberry St

15 FILED SEP 7 - 1921 ROBERT J. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5th, 1921, to Sept. 5th, 1921, that I last saw her alive on Sept. 5th, 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
(Heart Disease)
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No — Physician's Diagnosis

What test confirmed diagnosis? Difficult respiration

(Signed) L. B. Schwatka M. D.

. 19 (Address) 872 N. North Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount cemetery — DATE OF BURIAL Sept 7 1921

20 UNDERTAKER Chas. G. Black — ADDRESS 742 N. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Frothingham

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56752 X 64 D 56752

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 38 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ruth Frothingham

(a) RESIDENCE. No. Mt Hope Retreat ST. 28th WARD. (Boston Mass.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 25 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow —

5a If married, widowed, or divorced HUSBAND of (or WIFE of) widow of Mrs F.

6 DATE OF BIRTH (month, day, and year) About 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
over	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Not Known

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed SEP 7 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 13th, 1921, to Sept 7th, 1921, that I last saw her alive on Sept 6th, 1921, and that death occurred, on the date stated above, at 8.35 A. m.

The CAUSE OF DEATH* was as follows:

Chr - Nephritis - over 2 yrs -
Complicated by Cerebral Hemorrhage
- duration abt 10 days -

over (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia - Senile -

over (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted, if not at place of death? Probably Washington DC

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

Sept 7, 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge - Mass	Sept-7/ 1921
20 UNDERTAKER STEWART & MOWER COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 106 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56753

CERTIFICATE OF DEATH.

79 D 56753

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 838 Edmondson St.; 17 Ward)

2-FULL NAME Anna Wiechert

(a) RESIDENCE. No. 838 Edmondson St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edward Ferdinand Wiechart

6 DATE OF BIRTH (month, day, and year) Apl 22-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Schneidereit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Edward Ferdinand Wiechart
(Address)

15 Filed Burial Permit Clerk. Registrar

Robert P. Harrison, 7-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1920 to Sept 6, 1921, that I last saw h— alive on Sept 6, 1921, and that death occurred, on the date stated above, at 7 05 A.M.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Chr. organic Heart Disease

Pulmonary Lesion (duration) 10 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Conditions & History of Case - Jones Brown, M. D.
(Signed)

9/6. 1921 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Pauls Violetta Md	Sept 8 1921
20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56754

CERTIFICATE OF DEATH.

109 D 56754

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 Harlem St.: 16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Eleanor Richardson

(a) RESIDENCE. No. 1031 Harlem St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER James T. Richardson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Helen Schulte

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) U S A

14 Informant James T. Richardson
(Address) 1031 Harlem ave

15 Filed Sept 7 1921 19 Burial Permit Clerk. Registrar

Robert T. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1921, to Sept 6, 1921, that I last saw her alive on Sept 6, 1921, and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Intussusception of Bowel.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. Lahrde Ewell, M. D.

9/7. 1921 (Address) 905 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Sept 8th 1921

20 UNDERTAKER E. Rubert & Son ADDRESS 2503 Edmondson ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible]. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56755

CERTIFICATE OF DEATH.

42

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No 522 Arlington Ave ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida M. Johnson

(a) RESIDENCE. NO. 522 Arlington Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur J. Johnson

6 DATE OF BIRTH (month, day, and year) Oct Born 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Andrew Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Emma S. Hadley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Arthur J. Johnson (Address) 522 Arlington ave

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1— 1921, to Sept 5th— 1921, that I last saw her alive on Sept 4th 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of womb

about (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Samuel A Bain, M. D.

, 19 (Address) 437 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL Sept 8 1921

20 UNDERTAKER E. A. Wiedefeld ADDRESS 501 E. 22d St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Wiorek)

Spec.—6-9-19—B. P. Co.—1000 Blks.

D 56756 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56756

D 56756

CERTIFICATE OF DEATH. 130-091

REGISTERED NO.

1-PLACE OF DEATH City Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1 ST.: WARD)

2-FULL NAME Mary Wiarek

(a) RESIDENCE. NO. 210 Cambridge St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 50-60 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hosp. Records (Address)

15 Filed 9-7-1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9—5 1921

17 I HEREBY CERTIFY, That I attended deceased from 9—3, 1921, to 9—5, 1921, that I last saw her alive on 9—5—, 1921, and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gen. Path.

(Signed) Clyde McNeill, M. D.

9-7, 1921 (Address) City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL Sep 8 1921

20 UNDERTAKER John A Weber ADDRESS 1803 Bank

STATE EXACTLY. PHYSICIANS should be careful to have statements carefully supplied. All should be stated EXACTLY. PHYSICIANS should be careful to have statements carefully supplied. All should be properly classified. Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56757

CERTIFICATE OF DEATH.

105

D 56757

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1611 McCulloh ST.: 14 WARD)

2-FULL NAME George H. Price

(a) RESIDENCE. No. 1611 McCulloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
(or) Widow

6 DATE OF BIRTH (month, day, and year) Mar. 16, '83

7 AGE 38 Years 5 Months 21 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED 070

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Factory Gen'l helper in the Horton

(c) Name of employer and - Geo H. Price -

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant) Alice Neal
(Address) 1611 McCulloh

15 Filed Sept 8 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

P 7 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 31, 1921, to Sept 5, 1921, that I last saw him alive on Sept 5, 1921, and that death occurred, on the date stated above, at 2.40 p m.

The CAUSE OF DEATH* was as follows:

Heat-Stroke: Heart-failure: Enteritis.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exposure;

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Place of Employment

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal Physical Finding

(Signed) Edward Short - M. D.

9/6, 1921 (Address) 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem't.	Sept. 8 1921
20 UNDERTAKER	ADDRESS
Geo. H. Holland.	1631 Druid Hill Ave

Before signing, be careful to see that all items are correctly supplied. Any statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Kolodziejski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56758

D 56758

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 310 S. Duncan ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Kolodziejski

(a) RESIDENCE. NO. 310 S. Duncan WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " " "

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER James Kolodziejski

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Alvah Brancer

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Alva Kolodziejski
(Address) 310 S. Duncan

15 Filed 19 Robert P. Harrison, Registrar

P 7—1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept-3, 1921, to Sept. 6, 1921, that I last saw her alive on Sept 5, 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

a Cholera Infantum

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Ruhlberger, M. D.

19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL 9/7 '21

20 UNDERTAKER J. H. Fairgourt

ADDRESS 1606 E—

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56759

D 56759

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 46 Rosekemp Ave. St.: Lauraville Ward)

2-FULL NAME Adolph H. Kurzbacher.

(a) RESIDENCE. No. 46 Rosekemp Ave. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Hilda E. Kurzbacher

6 DATE OF BIRTH (month, day, and year) July 19th 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager 134

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery Store

(c) Name of employer Knoblick Bro's

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John F. Kurzbacher.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary G. Horstman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Hilda E. Kurzbacher. (Address) 46 Rosekemp Ave

15 Filed SEP 8 - 1921 19.. Registrar BOERNER & KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 1921, to Sept 7 1921, that I last saw h alive on Sept 7 1921, and that death occurred, on the date stated above, at 2. P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray + Clinical Symptoms

(Signed) [illegible], M. D.

9/7, 1921 (Address) 4706 Hampden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Sept 10 1921

20 UNDERTAKER: Jno. Mus. John H. Tenfelde Son — ADDRESS: 801 W Fayette

mation should be carefully supplied. Age should be stated in years. Occupation should be such that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 56760

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 X 24 ✓

D 56760

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Weldon Chairs

(a) RESIDENCE. NO. Mercy Hospital ST., WARD. Chestertown Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? 11 yrs. 3 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of (Single

6 DATE OF BIRTH (month, day, and year) May 23 1910

7 AGE	Years	Months	Days	If LESS than 1 day..... hrs. or min.
	11	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Chairs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Agnes Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Mrs J. S. Chairs (mother)
(Address) Chestertown Md

15 Filed SEP 8 - 1921, 19 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6 1921, to Sept 8, 1921

that I last saw h[illegible] alive on Sept 8 1921

and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Tetanus

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? No ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Signs + Symptoms

(Signed) D. J. Draguo M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown - Md

DATE OF BURIAL Sept 8 1921.

20 UNDERTAKER [illegible] & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Information should be carefully supplied. AGE should be stated EXACTLY. DISEASES should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56761

CERTIFICATE OF DEATH.

28 D 56761

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 McElderry ST.: 5th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie L. Price

(a) RESIDENCE. NO. 1232 McElderry ST., 5th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14		9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Wash. D.C.

PARENTS

10 NAME OF FATHER Chas D. Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Ophelia Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Ophelia Price
(Address) 1232 McElderry

15 Filed SEP 8 - 1921 ROBERT E. LEE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1921 to Sept 6th, 1921, that I last saw h[er] alive on Sept 6th, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Subacute nephritis (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lang Brooley, M. D.

9/7/21 (Address) 908 S Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Washington D.C.	Sept 8th 1921
20 UNDERTAKER Joseph F. Farrell	ADDRESS 1317 Druid

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Possibly tuberculous

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 56762

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 56762

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ..... Mercy Hospital St.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Holen

(Residence in Baltimore: No. 1021 Stiles St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Wid.

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
70 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... — 050
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Painter

9-BIRTHPLACE, (State or Country), PA

PARENTS.

10-NAME OF FATHER Henry Haten

11-BIRTHPLACE OF FATHER (State or Country), PA

12-MAIDEN NAME OF MOTHER Margarete Kenyn

13-BIRTHPLACE OF MOTHER (State or Country), PA

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Naumann

(Address) 9 S. Bond St

15- Filed SEP 8-1921 ROBERT J. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Inflamat. Infiltration Chr. Pneumonia

Pneumonia (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Riley M. D. (Coroner)

....., 191.. (Address) 16 S. E. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 5 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence. .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Sept. 8, 1921
20-UNDERTAKER	ADDRESS
Joseph Ahrens	221 N B Way

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 56763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56763

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2308 Essex ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William T. Phorbus.

(a) RESIDENCE. NO. 2308 Essex ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna. Phorbus.

6 DATE OF BIRTH (month, day, and year) 1864-9-12

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) DIS

(c) Name of employer — —

9 BIRTHPLACE (City or town) (State or country) Somerset Co. Md.

PARENTS

10 NAME OF FATHER Ed. E Phorbus.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co Md.

12 MAIDEN NAME OF MOTHER Mary K Dyer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co Md.

14 Informant Mary K Phoebus (Address) 227 N Collington Ave

15 Filed SEP 8 - 1921 Registrar ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Sept 7, 1921, that I last saw h[illegible] alive on Sept 6, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) R. Paraplegia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Typical

(Signed) E. E Phorbus, M. D.

(Address) 1163 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 8 1921
20 UNDERTAKER J Herwig & Co	ADDRESS 2008 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than one day, hours or minutes must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56764

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 56764

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 Corroll St., 21 WARD)

2-FULL NAME Robert W Childs

(a) RESIDENCE. No. 1331 Corroll ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-3-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
1 year.	1	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER John Childs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va Colo.

12 MAIDEN NAME OF MOTHER Virginia Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Childs
(Address) 1331 Carroll St.

15 Filed SEP 8-1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/6/ 1921

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1921, to Sept 6, 1921, that I last saw h[illegible] alive on 9/6/21, 19....., and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen L Davis, M. D.

, 19 (Address) 1227 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch Co	Sept 8 1921
20 UNDERTAKER John F. Denny	ADDRESS 75 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF DYING is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56765

CERTIFICATE OF DEATH.

79 D 56765

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 Valley St. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. J. McKenna

(a) RESIDENCE. NO. 1018 Valley St. ST., WARD.

(Usual place of abode) Lifetime (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate McFarland McKenna

6 DATE OF BIRTH (month, day, and year) Jan 10-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City Councilman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Peter McKenna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Kate McFarland McKenna

(Address) 1018 Valley St.

15 Filed SEP 8-1921 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1921, to Sept 6, 1921, that I last saw him alive on Sept 6, 1921, and that death occurred, on the date stated above, at 9 0 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

Rheumatism (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1018 Valley St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

9/6, 1921 (Address) 700 E Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 9/9 1921

20 UNDERTAKER Chas H. Evans & Son

ADDRESS 118 W. Mt Royal Ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D 56766

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56766

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mount Carmel Road St.; 1 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Gallizzi

(Residence in Baltimore: No. 270 S Robinson St.; Unknown yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M | 4-COLOR OR RACE, W | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct (Month) ....., 18..... (Day) (Year)

7-AGE, 68 yrs. 11 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Antony Gallizzi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Jessie Esso

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Gallizzi

(Address) 270 S Robinson

15- ROBERT J KRAUTER

Filed ....., 191. SEPT 7 1911 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep (Month) 5 (Day), 1911 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Wesley Lyas Coroner M. D.

9/5, 191 1 (Address) 1000 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincent	Sep 8, 1911
20-UNDERTAKER	ADDRESS
Wendell Dippold	378 N

D 56767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

186 D 56767

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 322 22 1/2 St.; 12th WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fred Dillard

(Residence in Baltimore: No. 322 - 22 1/2 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. April 29, 1921 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
....yrs. 4 mos. ....ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE. (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. Charles Dillard

11-BIRTHPLACE OF FATHER (State or Country). born in Va

12-MAIDEN NAME OF MOTHER. Freddie Dillard

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Freddie Dillard

(Address) 322 22 1/2 St

15- Filed SEP 8 - 1921, 191... ROBT. J. CARTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 7th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation Accidental

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner) Sept 7 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Sept 8, 1921
20-UNDERTAKER. Mrs R A Elliott	ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56768

CERTIFICATE OF DEATH.

71 D 56768

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2620 Fleet ST.: 1 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Dembeck

(Residence in Baltimore: No. 2620 Fleet St.: 1 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Sept (Month) 2 (Day), 1921 (Year)

7-AGE: ....yrs. 5 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Andy Dembeck

11-BIRTHPLACE OF FATHER (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andy Dembeck

(Address) 2620 Fleet St

15- SEP 8-1921 Filed ..... 191.... ROBERT J. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epileptiform Convulsions

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. Lynn Pinkard M. D.
(Coroner)

9-8-21 191... (Address) 1509 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	Sept 8, 1921
20-UNDERTAKER	ADDRESS
Stephen J Kalkowski	1000 S Kenwood Ave

Theresa Leicht

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56769

D 56769

CERTIFICATE OF DEATH.

x 70.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. N Fulton Ave St., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Theresa Leicht

(a) RESIDENCE. No. Berkley Springs 2nd ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of William E. Leicht

6 DATE OF BIRTH (month, day, and year): June 22 1882

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
39	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Joseph Baumann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Gustina Gaa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. Wm. E. Leicht (Address): Berkley Springs W. Va.

15 Filed SEP 8-1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/7/21

17

I HEREBY CERTIFY, That I attended deceased from Sept 3, 1921, to Sept 7, 1921,

that I last saw h[illegible] alive on Sept 7, 1921,

and that death occurred, on the date stated above, at 1.15 m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Symptoms

(Signed) C. C. Brunk M. D.

, 19 (Address) 4706 Hospital Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shrewsbury. Pa.	Sept 9 1921
20 UNDERTAKER	ADDRESS
Henry Worrell Son	1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Source of infection unknown.

Spec. 6-9-19 H. P. Co. 1000 Bks.

14 9/13

D 56770

HEALTH DEPARTMENT—CITY OF BALTIMORE D 56770

CERTIFICATE OF DEATH.

127

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital St.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Barry

(a) RESIDENCE. No. Johns Hopkins Hospital ST.. WARD. Richmond Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma E. Barry

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): Street Asphalt

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Portland Maine

PARENTS

10 NAME OF FATHER: Thos. Barry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maine

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Johns Hopkins Hospital

15 Filed SEP 6- 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 27. 1921. to Sept 7 1921. that I last saw h[illegible] alive on Sept 7 1921. and that death occurred, on the date stated above, at 5 45 pm

The CAUSE OF DEATH* was as follows:

Pyelonephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Stricture, Cystitis, diverticula,

(operation) (duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 29. 1921

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy.

(Signed) W. W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va — DATE OF BURIAL: 9/8 1921

20 UNDERTAKER: Chas F. Evans & Son — ADDRESS: 118 W. Mt Royal Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56771

CERTIFICATE OF DEATH.

28 D 56771

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1234 Right St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bredekamp

(a) RESIDENCE. No. 1234 Right St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Bredekamp

6 DATE OF BIRTH (month, day, and year): June 10, 1877

7 AGE — Years: 44 — Months: 2 — Days: 25 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St. Marys Co.

PARENTS

10 NAME OF FATHER: Thos. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): St. Marys Co.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St. Marys Co

14 Informant: Chas. Bredekamp
(Address): 1234 Right St

15 Filed ..... 19 ..... Registrar

SEP 0- 19- Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1921, to Sept 5, 1921, that I last saw her alive on Sept 5, 1921, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac & nephritis
asthenia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) ..... yrs. 11 mos. ..... ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Edward Barnes, M. D.

9/6, 1921 (Address) 1 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. — DATE OF BURIAL: Sep. 8 1921

20 UNDERTAKER: Margaret D. Flynn — ADDRESS: 1422 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. Particulars CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificate

Spec. 6-9-21—H. P. Co.—1000 Bks.

D 56772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 56772

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH City Hospital

CITY OF BALTIMORE: (NO. ..... ST.: 26 WARD)

2-FULL NAME John P. Perkins

(a) RESIDENCE. NO. md. Carlton ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker 088

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unk

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk

14 Informant Hosp. Records.
(Address)

15 Filed ..... 19.... Registrar.

SEP 8 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 30 . 1921 . to Sept. 3 . 1921 . that I last saw h alive on Sept 3 . 1921 . and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal syphilis with hemiplegia (thrombotic) ? ?

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal Tap Wass.

(Signed) Clyde McNeil, M. D.

9-8. 1921 (Address) City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cem.	Sept 8 1921
20 UNDERTAKER	ADDRESS
H. Sander Son	1710 Eut

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 [illegible] 1000 Bks.

D 56773

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56773

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Bay View Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Schlimn,

(a) RESIDENCE. No. 3925 East Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52 years	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Henry Ritter,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Mamie Howard (Address) 3811 Montebello Ave

15 Filed SEP 8 - 1921 16 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from 5/21/ 1921 to 9/7/ 1921

that I last saw her alive on 9/7/ 1921

and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of pelvic organs.

Over

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 6/1/21; & 7/8/21

Was there an autopsy? No.

What test confirmed diagnosis? Exploratory laparotomy.

(Signed) A. G. Hoheb, M. D.

19 (Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 10 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Pledge

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Originated in pelvis.

Spec.—1-10-21—M&T—1500 Bks.

D 56774 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56774

42

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2923 E. Baltimore ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine F. Schneider

(a) RESIDENCE NO. 2923 E Baltimore ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Schneider

6 DATE OF BIRTH (month, day, and year) Aug 11 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frederick Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Groff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Schneider (Address) 2923 E Baltimore St.

15 Filed SEP 8 1921 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1921, to Sept 6, 1921, that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Uterine Cancer

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible], M. D.

Sept 7, 1921 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept. 9 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Flat St.

N. B.—[illegible] should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Goldsmith

D 56775 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

100 D 56775

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 8 Lloyd St.; 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josie Goldsmith.

(Residence in Baltimore: No. 41 Lloyd. St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fml

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January 5, 1896
(Month) (Day) (Year)

7-AGE, 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Druggist
(b) General nature of industry, business, or establishment in which employed (or employer). 175

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Philip Goldsmith

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Fannie Mmelstein

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Leurs

(Address) 1411 E Balto St

15- SEP 8-1921 ROBERT J. KRAUTER

Filed ....., 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest) on the body and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Embolism during operation for Tonsolitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Nebraska Baltimore

DATE OF BURIAL, 9-9, 1921

20-UNDERTAKER Jack Leurs

ADDRESS 1411 E Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56776

CERTIFICATE OF DEATH.

175-08

D 56776

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Volunteer Hospital N Lanvale & Fy WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Samuel B. Hassow

(Residence in Baltimore: No 2108 aiken st — St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Aug (Month) 27 (Day), 1855 (Year)

7-AGE, 66 yrs. 10 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigarmaker
(b) General nature of industry, business, or establishment in which employed (or employer): 017

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm. Hassow

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Hassow

(Address) 2108 Aiken st

15-

SEP 8-1921

Filed ....., 191.... ROBERT J. KRAUTER

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Coroner, an~~ ~~coroner~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

fractured Skull

(Duration) yrs. mos. a few minutes ds.

CONTRIBUTORY (Secondary) Struck by Automobile

(Duration) yrs. a few minutes mos. ds.

(Signed) W. K. Freeman M. D.
(Coroner.)

9-7, 1921 (Address) 117 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Sept 9, 1921

20-UNDERTAKER F. A. Krause & Son. ADDRESS 703 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56777

CERTIFICATE OF DEATH.

136 D 56777

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (NO. Lombard + Greene ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Johnson

(a) RESIDENCE. NO. 427 Merrymans Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Mathew Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ada Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Arthur A. Johnson.
(Address) 427 Merrymans Ave.

15 Filed SEP 8 - 1921 19 ... Registrar

BOARD OF HEALTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 7, 1921, that I last saw her alive on Sept 7, 1921, and that death occurred, on the date stated above, at 3.55 m.

The CAUSE OF DEATH* was as follows:

General Peritonitis and
General Septicemia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pregnancy abdominal Caesarean Section (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of Sept 1 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Reese, M. D.

9-7. 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Sept 9 1921
20 UNDERTAKER	ADDRESS
Felix B. Pyz	102 E Mulberry St

N. B.—WRITE PLAINLY. PHYSICIANS should be careful in stating the cause of death. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56778 ✓ D 56778

CERTIFICATE OF DEATH.

D 56778

REGISTERED NO. 14/1048

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 Penna ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard K. Kavanaugh

(a) RESIDENCE. No. 1833 Penna ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 28-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Edward W Kavanaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Ester M. Dulaber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Missouri

14 Informant Charles W. Kavanaugh
(Address) 1833 Penna ave

15 Filed SEP 8-1921 AUGUST F KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 21

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 7, 1921, that I last saw h.m alive on Sept 7, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Whooping cough
Influenza + did not treat
Same no report (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Enteritis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin Murray M. D.

. 19 (Address) 1721 W. Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL Sept 8 21

20 UNDERTAKER Daniel Easter

ADDRESS 916 Pa ave

N. B.—Blanks should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be of certificates. See instructions on back of TION is very important.

Trudie England.

D 56779 HEALTH DEPARTMENT—CITY OF BALTIMORE

X 155 D 56779

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Trudie England

(Residence in Baltimore: No. 1219 N. Charles St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH, Jan (Month) 19 (Day), 1899 (Year)

7-AGE. 22 yrs. 7 mos. 18 ds. | If LESS than 1 day, ... hrs. or ... mins.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... None
(b) General nature of industry, business, or establishment in which employed (or employer) ... 037

9-BIRTHPLACE (State or Country). Texas

PARENTS.

10-NAME OF FATHER. J. E. Alexander

11-BIRTHPLACE OF FATHER (State or Country). ~~Texas~~ Ky

12-MAIDEN NAME OF MOTHER Sallie Audubon

13-BIRTHPLACE OF MOTHER (State or Country). Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H England

(Address) 1219 N Charles st

15- Filed ... 191... Registrar.

Robert F. Harrison,
Burial Permit Clerk.

SEP 8 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Bichloride Mercury poisoning
7 hrs. (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
... (Duration) ... yrs. ... mos. ... ds.

(Signed) H. J. Riley M. D.
(Coroner) Sept 7, 1921 (Address) 1637 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death 7 8 days In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence Texas.

19-PLACE OF BURIAL OR REMOVAL. Denison Texas | DATE OF BURIAL. 9/8, 1921

20-UNDERTAKER Geo E Darby | ADDRESS Fulton & Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 56780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56780

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Morrow Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L. Buck

(a) RESIDENCE NO. 2200 Boyer ST., ...WARD ....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary L. Buck

6 DATE OF BIRTH (month, day and year): Jan — 1854

7 AGE: Years 67 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): 140

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt

PARENTS

10 NAME OF FATHER: Leander Buck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt

12 MAIDEN NAME OF MOTHER: Margaret E. Schilling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt

14 Informant: Mary L Buck

(Address) 928 Hackett

15 Filed Sept 8 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1921, to Sept 7, 1921, that I last saw him alive on Sept 7, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bladder Carcinoma.

(duration) 1 yrs. mos 6 ds.

CONTRIBUTORY (Secondary): Hemorrhage (Bleeding)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) G. H. Keirle, M. D.

, 19 (Address) Morrow Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 9/9/19 21

20 UNDERTAKER: J. A. Inman

ADDRESS 3000 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56781

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 St. Paul st. St. 11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B Ramsay

(a) RESIDENCE. No. 1218 St. Paul st. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a If married, widowed, or divorced
HUSBAND of ~~(or WIFE of)~~ Mary Cullen Ramsay

6 DATE OF BIRTH (month, day, and year) Nov 18, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Banker 186

(b) General nature of industry, business, or establishment in which employed (or employer): Bank President

(c) Name of employer: M & M. Bank.

9 BIRTHPLACE (city or town) (State or country): Port Deposit Maryland.

PARENTS

10 NAME OF FATHER: Jefferson Ramsay

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk Virginia

12 MAIDEN NAME OF MOTHER: Marian Falconer (Mrs. Fenton)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant (Address): George E. Gross 1007 Calhoun st.

15 Filed Sept 9 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1921, to Sept 7, 1921, that I last saw h im alive on Sept 7, 1921, and that death occurred, on the date stated above, at 4 15 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma.

(duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary) Myocardial decompensation (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Feb. 1921

Was there an autopsy? no.

What test confirmed diagnosis? Operation

(Signed) George E. Gross, M. D.

, 19 (Address) 1007 Calhoun st.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 9 1921

20 UNDERTAKER: John B. Spence, 1525 N. Caroline St

ADDRESS

SEP 9-1921

...S A PERMANENT RECORD—THEREFORE UNFADING INK—THE ... should be stated EXACTLY. AGE should be carefully supplied. ... that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56782

D 56782 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Davis (?)

(a) RESIDENCE. NO. ? ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35 (?)			

8 OCCUPATION OF DECEASED ? 089

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed , 19 Robert P. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1921, to Sept 6, 1921, that I last saw him alive on Sept 6, 1921, and that death occurred, on the date stated above, at 7 45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of meninges

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) anemia

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys. Exam. + Spinal puncture

(Signed) D. J. Gregg, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER	ADDRESS

Commissioner Health. SEP 1921

Burial Permit Clerk.

CAUSE OF DEATH ... TION is very important. See instructions on back of certificates. Exact ... properly classified. Exact ... NT ... EXACTLY.

D 56783 HEALTH DEPARTMENT—CITY OF BALTIMORE Abrueschweiler

CERTIFICATE OF DEATH. 15 D 56783

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 413 S. Caroline 3rd Flr. ST.; 3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and WARD No. 18.)

2-FULL NAME Not Named, (Abrueschweiler
(Residence in Baltimore: No. 413 S. Caroline St. 3rd Flr, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M | 4-COLOR OR RACE, W | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 6, 1921
(Month) (Day) (Year)

7-AGE. yrs. mos. ds.
If LESS than 1 day, 6 hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Geo Abrueschweiler

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Frances Klorek

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Robert P. Harrison,
Filed ....., 191.... Registrar.
SEP 8-1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.
The CAUSE OF DEATH* was as follows:
Premature Birth
(Duration) yrs. 1 mos. 6 hrs ds.
CONTRIBUTORY Asphyxia
(Secondary)
(Duration) yrs. mos. ds.
(Signed) E. L. Gladden M. D.
(Coroner)
Sept 7, 1921 (Address) 1436 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL
DATE OF BURIAL, ..., 19....

20-UNDERTAKER Commissioner Health.
ADDRESS SEP 1921

Wm. E. WOODALL

CAUSE OF DEATH in plain terms. Exact statement of cause is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56784

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 56784

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 418 E. Lanvale ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (no name) Infant of Wm. & Edith Phillips

(a) RESIDENCE. NO. 418 E Lanvale ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. (10 minutes) mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 7-1921

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 10 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wilhelm Albert Phillipps

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Edith Belt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Edith Phillipps
(Address) 418 E Lanvale St.

15 Filed SEP 8 1921 Robert F. Garrison, Registrar

Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1921, to Sept 7, 1921.

that I did not see her alive on Sept 7, 1921.

and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chester Riland., M. D.

9-7. 1921 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 SEP 1921

20 UNDERTAKER

Per Wm. E. WOODALL Commissioner Health.

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

D 56785 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56785

CERTIFICATE OF DEATH.

169

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hartsdale Hamilton Ay ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

Unknown

(Residence in Baltimore: No. ..... St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Unknown

6-DATE OF BIRTH, ... Unknown ....., 1..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
about 42 Unknown yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)..... 08

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carlin Tabler Study

(Address) Baltimore

15- Filed ....., 191.....

Robert F. Harrison, Registrar.

SEP 8 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) Investigation find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. Coroner

9/8 ....., 1921 (Address) 1800 Hanover Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
PUBLIC CEMETERY	....., 19...
20-UNDERTAKER Commissioner Health.	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WOODALL

D 56786 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56786

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Shack, Standard Guano Co. ST.: Curtis Bay. 25 WARD) 79

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James McCalster.(C)

(Residence in Baltimore: No. Shack, Standard Guano Co. Curtis Bay. St.: 5. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH,
.....Do not know....., /.....
(Month) (Day) (Year)

7-AGE,
.....37.....yrs.....mos.....ds.

If LESS than 1 day,
....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),
Georgia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Partlow.(C)

(Address) Shack, Standard Guano Co. Curtis Bay.

15-

Filed....., 191.....

Registrar.

SEP 8- 1921

Robert P. Harrison,
Commissioner Health.
Per Wm E. WOODALL
Assistant Deputy Clerk

CAUSE OF DEATH in plain terms. important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,
.....August 29th. 1921....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner.)

Aug. 29. 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
PUBLIC CEMETERY	....., 19...
20-UNDERTAKER	ADDRESS

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56787 ✓ 82 D 56787

D 56787

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2638 Huntingdon Ave ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan B. Chaffman

(a) RESIDENCE. No. 2638 Huntingdon Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs - mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. H. Chaffman

6 DATE OF BIRTH (month, day, and year) June 2-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 100

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Maryland

PARENTS

10 NAME OF FATHER John H. Crabson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Maryland

12 MAIDEN NAME OF MOTHER Rebecca Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Maryland

14 Informant (Address) Mrs. Edward C. Hughes 2638 Huntingdon Ave

15 Filed SEP 9 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6. 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1921, to Sept 6, 1921, that I last saw h.. alive on Sept 5 1921, and that death occurred, on the date stated above, at 11 45 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema & pulmonal abscess

Pregnant (duration) yrs. mos. 07 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General symptoms

(Signed) R. B. Howard, M. D.

9.7. 1921 (Address) 3047 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden) DATE OF BURIAL Sept. 9- 1921

20 UNDERTAKER Horace H. Burgee ADDRESS 3631 Falls Rd

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56788

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56788

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2466 Greenmount ST.; 17 WARD)

2-FULL NAME Frank J. Dess

(a) RESIDENCE. No. 2466 Greenmount ST.. WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Dess

6 DATE OF BIRTH (month, day, and year): Nov 10-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED 030

(a) Trade, profession or particular kind of work: Stationary Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: Sexton Stove Works Balto

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Francis X. Dess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Agnes C. Rose

(Address): 2466 Greenmount

15 Filed SEP 8-1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): September 7th 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 28 nd 1921, to Sept 7th 1921, that I last saw h[illegible] alive on Sept 7th 1921 and that death occurred, on the date stated above, at 1130 A.M.

The CAUSE OF DEATH* was as follows:

Pulmo-Pneumonia

(duration) yrs. mos 16 ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Geo Morgan M.D. M. D.

9/7 1921 (Address) 401 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 10, 1921
20 UNDERTAKER, William Cook	ADDRESS 5022 Harford

CAUSE OF DEATH in plain terms. So that a non-medical person may understand. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56789 D 56789

CERTIFICATE OF DEATH.

42

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2027 Madison Ave St.: 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Rosenblatt

(a) RESIDENCE. No. 2037 Madison Ave St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moses Rosenblatt

6 DATE OF BIRTH (month, day, and year) June 15 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - Md

PARENTS

10 NAME OF FATHER Henry Goldsmith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Osterday

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. L. Schoenemann (Address) Owens & Pratt

15 Filed [illegible] H. Harrison, Registrar

SEP 8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 19 21

17 I HEREBY CERTIFY, That I attended deceased from ....., 19...., to Sept. 7, 19....,

that I last saw h.... alive on Sept. 7, 19....,

and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

(duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) 1 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 1, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Theodore Morrison M. D.

, 19 (Address) 1213 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	Sept 9 1921
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	614 Mad ave

IMPORTANT: Write DEATH CERTIFICATE in plain terms, so that it may be understood by all. CAUSE OF DEATH in plain terms, so that it may be understood by all. CAUSE OF DEATH in plain terms, so that it may be understood by all. CAUSE OF DEATH

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56790 ✓ D 56790

D 56790

CERTIFICATE OF DEATH.

61

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2131 N. Mulberry ST., 20 WARD)

2-FULL NAME Ellen Elizabeth Hanshew

(a) RESIDENCE NO. 2131 N. Mulberry ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4-1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	12	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Frederick Md.

PARENTS

10 NAME OF FATHER John F. Hanshew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fred'k Md.

12 MAIDEN NAME OF MOTHER Lillian King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fred'k Md.

14 Informant John F. Hanshew (Address) 2131 N. Mulberry

15 Filed ..... 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk.

8-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1921, to Sept 7, 1921, that I last saw h[illegible] alive on Sept 7, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows: OVER

Cerebral Meningitis

(duration) yrs. mos 3 1 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Sent spinal fluid to Health Dept. - Meningococcus only dom

(Signed) M Beauman Lord, M. D.

9/7, 1921 (Address) 626 N Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick. Md

DATE OF BURIAL Sept 9 1921

20 UNDERTAKER Wm. J. Tickner & Son

ADDRESS N. Pa

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. Hood does not think it epidemic.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56791 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56791

CERTIFICATE OF DEATH. 172

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 32 S. Schroeder ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Grunholzer.

(a) RESIDENCE. (No.) 32 S. Schroeder ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Grunholzer

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 69. Months: 2. Days: 18

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Switzerland

PARENTS

10 NAME OF FATHER: Conrad Hirtzer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Lane Zeller.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant (Address): John Grunholzer 32 S. Schroeder St.

15 Filed 19 Robert F. Harrison, Registrar

8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to (6th) ....., 19.....,

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at 6.15 A. m.

The CAUSE OF DEATH* was as follows:

Septicemia from Bedsore -

(duration) ..... yrs. 2 mos. 21 ds.

CONTRIBUTORY (Secondary) Fracture of left hip

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? X-Ray 1 wk. (own)

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) F. W. Wanner, M. D.

(Address) 1501 Bank Loan Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cremation Loudon Park DATE OF BURIAL: Sept 9. 1921

20 UNDERTAKER: Mrs. Mrs John H Penfold ADDRESS: 1501 W. Fayette

CAUSE OF DEATH. See instructions on back of CERTIFICATE. INFORMATION is very important.

(Stasenkiewicz)

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 56792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56792

8-091

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. Johns Hopkins Hospital ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Stasenkiewicz

(a) RESIDENCE. NO. 122 S. Wolfe St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31-1920

7 AGE: Years 1, Months 3, Days —, If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jose Stasenkiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Josephine Stryzewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed 9-8-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1921

17 I HEREBY CERTIFY, That I attended deceased from July 23 - 1921. to Sept 8 - 1921. that I last saw h[illegible] alive on Sept 8 - 1921. and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Pertussis (duration) 1 mo. 14 ds.

Dysentery

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Stool culture - Hiss -

(Signed) Horace G. Stewart, M. D.

9-9-21 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary. DATE OF BURIAL: Sept. 10 1921

20 UNDERTAKER: Wm Fiallowski ADDRESS 1618 Eastern

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56793

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56793

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dobrzycki

(a) RESIDENCE. No. 529 S. Bond ST., WARD. Hall II G 29

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Mathew Bagnatz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Annie Rogalska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Walter Dobrzycki

(Address) 529 S. Bond St.

15 Filed ....., 19.... Robert F. Harrison, Registrar

Burial Permit Clerk.

8-1921

CAUSE OF DEATH. See instructions on back of this TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1921, to Sept. 8, 1921, that I last saw h[illegible] alive on Sept. 8, 1921 and that death occurred, on the date stated above, at 3.25 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Sept 11 1921
20 UNDERTAKER, Wm F. Allewalt & Eastern	ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D 56794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 091 D 56794

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3913 Mt Pleasant Av ST., 7th WARD)

2-FULL NAME John Conrad Wohlhaas.

(a) RESIDENCE NO. 3913 Mt Pleasant ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City.

PARENTS

10 NAME OF FATHER George Wohlhaas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Agnes Haug.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant George Wohlhaas.
(Address) 3913 Mt. Pleasant Av

15 Filed SEP 9-1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/29/21, 19 , to 9/6/21, 19 ,
that I last saw him alive on 9/6/21, 19 ,
and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

Ileo colitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. J. McGarrell, M. D.

(Address) 633-5-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Sept 9 1921

20 UNDERTAKER Lilly & Zeile

ADDRESS Hoffman

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56795

CERTIFICATE OF DEATH.

28 D 56795

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 543 Mosher St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Gantt

(Residence in Baltimore: No. 543 Mosher St.; 34 yrs. — mos. 7 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1887 (Year)

7-AGE, 34 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Levi Gantt

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Herbert

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ada Thomas

(Address) 543 Mosher St

15- SEP 9-1921 ROBERT I KRAUTER

Filed ..., 191.. Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 6, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3, 1921, to Sept 6 1921, that I saw h[illegible] alive on Sept 6 1921, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) 2 yrs. mos. ds.

(Signed) W. V. Cam M. D.

Sept 9, 1921. (Address) 515 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cem. DATE OF BURIAL. Sept 9, 1921

20-UNDERTAKER Saml Kemsley ADDRESS 1111 Bridge St

HEALTH DEPARTMENT—CITY OF BALTIMORE

56796

CERTIFICATE OF DEATH.

19 D 56796
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Philadelphia & North Ave. St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George J. Oberndt

(Residence in Baltimore: No. 421 N Calhoun St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Jan 14, 1868
(Month) (Day) (Year)

7-AGE. 53 yrs. 9 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Varnisher
(b) General nature of industry, business, or establishment in which employed (or employer). 051

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Jacob Oberndt

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Lambach

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J Oberndt

(Address) 421 N Calhoun St

15- ROBERT J. KRAUTER

Filed SEP 8 1921, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide by Drowning

Death instantaneous (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Grau M. D.
(Coroner)

9/8/21, 191.. (Address) 1 W Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel

DATE OF BURIAL, 9, 1921

20-UNDERTAKER Henry Deutz

ADDRESS 1007 N Bond

N. B.—EVERY BLANK must be filled out. Write plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Omissions will delay burial permit. Typewriting is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Aaron J. Finger ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56797

CERTIFICATE OF DEATH.

130-091 D 56797

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr Aaron Finger

(Residence in Baltimore: No. 1801 Clifton ave St. 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH. Unknown (Month) (Day) 1849 (Year)

7-AGE. 72 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired 45
(b) General nature of industry, business, or establishment in which employed (or employer). Clothing Merchant

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Balto st

15- SEP 9-1921 ROBERT J KRAUTER

Filed....., 191.... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from aug 23 1921, to Sept 8 1921, that I saw him alive on Sept 5 1921, and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(Duration) ....yrs. ....mos. ....ds.

(Signed) Charles L. Levy M. D.

Sept. 8, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 16 ds. In the State 30 yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 1801 Clifton ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, 9—9..., 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto st

CAUSE OF DEATH important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 56798

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2538 E. Monument St. ST.: 7 WARD)

2-FULL NAME Walburga. C. Tress

(a) RESIDENCE. No. 2538 E. Monument St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. - mos. - ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter. J. Tress

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	47	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Anton Freede

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Anna Bruns

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant M. Walter J. Tress (Address) 2538 E Monument St

15 Filed . 19 ... ROBERT J. KRAUSE Registrar

SEP 9 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9. 1921

17 I HEREBY CERTIFY, That I attended deceased from November, 1920, to Sept 7, 1921, that I last saw h.. alive on Sept 7, 1921, and that death occurred, on the date stated above, at 6.30 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Boyd M. D.

Sept 9, 1921 (Address) 2005 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 13' 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 56799

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56799

103

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 W. Franklin ST., 18 WARD)

2-FULL NAME John H. Carter

(a) RESIDENCE NO. 922 W. Franklin ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Walter C Carter

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Mary C. Mc. Manus

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs Walter C Carter
(Address) 922 W Franklin St

15 Filed ..... 19 ..... Registrar

SEP 8 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1924, to Sept 6, 1924, that I last saw him alive on Sept 6, 1924, and that death occurred, on the date stated above, at 12.20 a m.

The CAUSE OF DEATH* was as follows:

Pernicious vomiting, (acidosis) TOXEMIA

(duration) ..... yrs. ..... mos 16 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. E. Knipp, M. D.

1924 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Sept 9 1924
20 UNDERTAKER J. J. Howard & Son	ADDRESS 901 Hollins St.

REGISTERED SEP 8 1921 Registrar

State Board of Health

IMPORTANT.—Please write plainly in ink, and state CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause of vomiting could not be determined. No further history than child would eat anything, linoleum etc.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 45 D 56800

D 56800

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 7 WARD)

2-FULL NAME Mrs. Louise J. Whaley

(a) RESIDENCE. NO. Springfield Ohio ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Earl E. Whaley

6 DATE OF BIRTH (month, day, and year) June 10 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER A. B. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Louise Crane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Johns Hopkins Hospital (Address)

15 Filed SEP 9 — 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to Sept 9, 1921, that I last saw her alive on Sept 9, 1921, and that death occurred, on the date stated above, at 1:00 m.

The CAUSE OF DEATH* was as follows:

Dareoma et ileum.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Secondary Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Ohio

Did an operation precede death? Yes Date of Sept 8 1921

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam. of section & tumor.

(Signed) H. K. Oberndorfer M. D.

9/9/, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Springfield Ohio

DATE OF BURIAL Sept 9 1921

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 N Broadway

COMPARED BY

Burial Permit Clerk

N. B.—WRITE PLAINLY. WITH INK. All information should be carefully supplied. AGE should be properly classified. EXACT information should be carefully supplied. AGE should be properly classified. EXACT CAUSE OF DEATH in plain terms, so that it may

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56801 D 56801

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED No. C 50

CITY OF BALTIMORE: (No. 547 Pressman ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie R. Bruce

(Residence in Baltimore: No. 547 Pressman St.; 56 yrs., 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	colored	Married

6-DATE OF BIRTH, Aug. (Month) 6 (Day), 1865 (Year)

7-AGE, 56 yrs. 1 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher 068
(b) General nature of industry, business, or establishment in which employed (or employer): Public Schools

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Benj. Eggleston

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER H. Catherine Price

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roscoe D. W. Price

(Address) 547 Pressman St.

15-

Filed....., 191.....

Registrar.

CAUSE OF DEATH. This information is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21, 1921, to Sept. 7th 1921, that I saw h... alive on " " 1921, and that death occurred, on the date stated above, at 12.1[illegible] p. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

which form a history of

case that have often

of about (Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Coma

about 24 hrs. (Duration) yrs. mos. ds.

(Signed) J. Francis C. Price, M. D.

Sept 10, 1921 (Address) 1212 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Sept. 10, 1921
20-UNDERTAKER Jno. M. Johnson	ADDRESS 1234 Eutaw St.

Spec.—8-24-14—M. & T.—2000 Bks.

56802 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56802

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 E. Madison St.; 14 WARD) REGISTERED NO. C 1464

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Peter Broadwater

(Residence in Baltimore: No. 1901 E. Madison St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, June (Month) 21 (Day) 1849 (Year)

7-AGE, 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Fisherman
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Daniel Broadwater

11-BIRTHPLACE OF FATHER (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER Mary Ann Shepherd

13-BIRTHPLACE OF MOTHER (State or Country), New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Kate McCall

(Address) 1901 E. Madison St.

15- SEP 9-1921 ROBERT J. KRAUTER Registrar.
Filed ....., 191....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 9th (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1921, to Sept 9 1921, that I saw him alive on Sept 8 1921, and that death occurred, on the date stated above, at 7:50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(Duration) 15 yrs. 6 mos. ds.

(Signed) Wm. D. Fitch M. D.

Sept 9, 1921 (Address) 926 Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Havre de Grace Md. DATE OF BURIAL, 9/9/21

20-UNDERTAKER E. & B. Hale ADDRESS 45 Edmondson

Cross out what is not important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

56803

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56803

CERTIFICATE OF DEATH

138

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. Johns Hopkins Hospital ST.; 22 WARD)

2-FULL NAME Connelly, Florence Mrs.

(a) RESIDENCE NO. 1412 So. Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred all her life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): married.

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Edward Connelly.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Mayland.

PARENTS

10 NAME OF FATHER: James Ross.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.
12 MAIDEN NAME OF MOTHER: Anna McMahon
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Johns Hopkin Hospital

15 Filed SEP 9 - 1921 19 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7th 1921

17 I HEREBY CERTIFY, That I attended ~~deceased~~ from Sept 7th 1921. to Sept 7th 1921. that I last saw her alive on Sept 7th 1921. and that death occurred, on the date stated above, at 9.35 p.m.

The CAUSE OF DEATH* was as follows:

Eclampsia (Post-partum)
Complicating pregnancy.
8 hours (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis? —

(Signed) H. H. Cathrall, M. D.
19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cem	9/10 1921
20 UNDERTAKER: John A. Johnson	ADDRESS: 1318 Light St

CAUSE OF DEATH ... TION is very important. See instructions on back of certificate.

Form —6-9-19— H. P. Co.— 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56804

CERTIFICATE OF DEATH.

43

D 56804

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1012 W. Lombard St. ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin C. Badger

(a) RESIDENCE. No. 1012 W. Lombard St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Badger

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt.	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter (Self)

(b) General nature of industry, business, or establishment in which employed (or employer): O.I.S.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James B. Badger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Eliza Beth Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Mrs. Mary E. Badger, 1012 W. Lombard St.

15 Filed SEP 9 - 1921, 19 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6" 19 21

17

I HEREBY CERTIFY, That I attended deceased from July, 19 21, to Sept 6, 19 21, that I last saw h— alive on Sept 5, 19 21, and that death occurred, on the date stated above, at 10.45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Carcinoma of Lung

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) [illegible] M. D.

9/7, 19 (Address) 1012 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 9" 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto St.

TION is very important. See instructions on back of certificate.

D 56805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 - D 56805

1-PLACE OF DEATH

CITY OF BALTIMORE (No. John Hopkins Hosp. V WARD)

2-FULL NAME Fannie Burneston

(Residence in Baltimore: No. 104 S Regester St.; yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ..., 1863
(Month) (Day) (Year)

7-AGE. 58 yrs. ... mos. ... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Rhinlod Zorn

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Wood Known

13-BIRTHPLACE OF MOTHER (State or Country). Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Holland

(Address) 104 S Regester St.

15-

Filed SEP 9-1921, 191 ROBERT I KRAUTER Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said
(Inquest, autopsy or Inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Will be held pending today.
Fracture skull
and burns (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(Duration) ... yrs. ... mos. ... ds.

(Signed) Wilkey M. D.
(Coroner.)
Sept 9, 1921. (Address) 1007 Fay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem.	Sept 12th, 1921.
20-UNDERTAKER	ADDRESS
Wm H Wm, Mar	37 Dol

Accidentally struck by street car

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56806

D 56806

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1448 Covington ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leslie Wm Evans Bareis

(a) RESIDENCE. No 1448 Covington ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Sing

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 3 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Leslie Wm Evans

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Bareis

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Carrie Bareis
(Address) 1448 Covington St

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk

CAUSE OF DEATH TION is very important. See instructions on back of certificate

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9.9 1921

17 I HEREBY CERTIFY, That I attended deceased from 9.9 1921, to 9.9 1921, that I last saw him alive on 9.9 1921, and that death occurred, on the date stated above, at 8.10 a.m.

The CAUSE OF DEATH* was as follows:

Convulsions

8 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis (Teething) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. J. Turlington, M. D.

, 19 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — London Pk Cem

DATE OF BURIAL 9/10 19 21

20 UNDERTAKER — J. Few McCully

ADDRESS 130 E. Fort

D 56807

D 56807

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1602 Guilford Av ST.: 12 WARD)

2-FULL NAME Blandina Erich Cruse

(a) RESIDENCE. No. 1602 Guilford Av ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of Charles H Cruse

6 DATE OF BIRTH (month, day, and year) July 2nd 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frederick Erich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Brea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Germany

14 Informant Charles H Cruse (Address) 1602 Guilford Ave

15 Filed Sept 9 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1921, to Sept 8, 1921, that I last saw h~~er~~ alive on Sept. 8, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

Chronic Nephritis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Gustav H. Wolferseck, M. D.

Sept. 9, 1921 (Address) 1210 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 10th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

CAUSE OF DEATH must be given by physician. Certificate is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56808 HEALTH DEPARTMENT—CITY OF BALTIMORE

STILL BIRTH

15 D 56808

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 W Camden St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Grant

(Residence in Baltimore: No. 34 W Camden St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept. 9th, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ---
(b) General nature of industry, business, or establishment in which employed (or employer) ---

9-BIRTHPLACE, (State or Country) 34 W Camden St

PARENTS.

10-NAME OF FATHER, Thomas Grant

11-BIRTHPLACE OF FATHER (State or Country) Virginia (B.V.)

12-MAIDEN NAME OF MOTHER Emma Young

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Grant

(Address) 34 W Camden St

15- Robert P. Harrison,

Filed ..... 191.....

SEP 1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 9th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10th, 1921, to Sept 10th, 1921; that I saw h[illegible] alive on Sept 10th, 1921, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Premature birth

Mother toxemia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Mother toxemia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Sept 10, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER, Commissioner Health.

ADDRESS SEP

Asst. Wm. E. WOODALL

IMPORTANT. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 56809

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56809

CERTIFICATE OF DEATH.

REGISTERED NO. 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1551 Clifton Ave ST.: 13 WARD)

2-FULL NAME (no name) baby Fulmer

(a) RESIDENCE. NO. 1551 Clifton Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9-8-21

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. ±40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Edgar Fulmer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Mary Myrtle Lighter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Middletown Md.

14 Informant (Address) Mary Myrtle Fulmer. 1551 Clifton Ave

15 Filed —, 19 Robert T. Harrison, Registrar

9 1921 Burial Permit Clerk

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-8 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-8, 1921, to 9-8, 1921, that I last saw her alive on 9-8, 1921, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chester Riland, M. D.

9-9. 1921 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER Commissioner Health, SEP	ADDRESS 1921

per Wm E. WOODALL

Spgc. 6-9-19 H. P. Co. 1000 Blks.

D 56810

D 56810

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56810

CERTIFICATE OF DEATH.

X 74

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital St.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Browning

(a) RESIDENCE. NO. 700 Buchanan St. Lynchburg ST.: Va. WARD. Lynchburg Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24 - 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Price Browning.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Mary Warren

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Johns Hopkins Hospital Branch

15 Filed Sep 9-1921 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8. 1921

17 I HEREBY CERTIFY, That I attended deceased from June 3. 1921. to Sept 8. 1921.

that I last saw her alive on Sept 8 1921.

and that death occurred, on the date stated above, at 11 22 a m.

The CAUSE OF DEATH* was as follows:

Hypophyseal Tumor

OVER

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Sept 8, 1921

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Emil Holman, M. D.

7-7-21 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lynchburg Va	9/9/21

20 UNDERTAKER H E Hughes Hdt ADDRESS 1st & Broadway

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tumor of pituitary body Exact nature of same not determined but probably adenoma

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 56811

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56811

CERTIFICATE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH South Balto. General Hospital 174

CITY OF BALTIMORE: (No. 1213-17 Light ST.: 6 WARD)

2-FULL NAME Robert Bailey

(a) RESIDENCE. NO. 132 N. ~~Eutaw~~ Chapel ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

(a) If married, widowed, or divorced, HUSBAND of (or) WIFE of Carrie Bailey

6 DATE OF BIRTH (month, day, and year) ? 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) F. S. Royster Guano Co.

(c) Name of employer Curtis Bay Maryland.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Isaac Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

11 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

Robert F. HARRISON,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 18 . 1921 . to Sept. 6 . 1921 .

that I last saw him alive on Sept. 6 . 1921 .

and that death occurred, on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows: Accidental O-M-R

1. Primary Compound comminuted fracture of rt. knee joint

2 Broncho-pneumonia ~~ovo~~

(duration) .. yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. 4 ds.

Accident at Royster Guano Co Curtis Bay. Md.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 18, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. A. Johnson, M. D.

, 19 (Address) Brooklyn, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Widgeon Mfg. Somerset Co Md	Sept. 10 1921
20 UNDERTAKER Robert E. Williams	ADDRESS 1104 Ashland Ave

TION is very important. See instructions on back

P 9-1921

[illegible] UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Caught between two cars in the factory. cars used for transferring material in the factory.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56812 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56812

CERTIFICATE OF DEATH. 28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 N. Poppleton ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Wyatt

(Residence in Baltimore: No. 418 W. Poppleton St.; 7 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, ~~MARRIED, WIDOWED,~~ OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1891 (Year)

7-AGE, 30 yrs. 2 mos. ..... da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Cook
(b) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Gloucester Co Va

PARENTS.

10-NAME OF FATHER, Geo Randle

11-BIRTHPLACE OF FATHER (State or Country) Gloucester Co Va

12-MAIDEN NAME OF MOTHER Fanny Wyatt

13-BIRTHPLACE OF MOTHER (State or Country) Gloucester Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felix B. Pope

(Address) 102 E. Mulberry St

15-

Filed ....., 191.....

Robert F. Harrison,
Registrar.

Burial Permit Clerk

SEP 9- 1921

CAUSE OF DEATH must be stated. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 30 1921, to 9-8-21 191....., that I saw h[illegible] alive on ....., 191....., and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 1½ mos. ..... da.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) J. W. Cardozo M. D.

9-8-21, 191... (Address) 524 Druid Hill Ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn DATE OF BURIAL. Sept 11, 1921

20-UNDERTAKER Felix B. Pope ADDRESS 102 E Mulberry St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 56813

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1008 Sharp (St.) 23 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. W. Amespacher

(a) RESIDENCE. No. 1008 Sharp St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 7/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo. Amespacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Anna Coff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Geo Amspacher (Address) 1008 Sharp St.

15 Filed Sep 9 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1921, to Sept 9, 1921, that I last saw h[illegible] alive on Sept 9, 1921, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H. R. Campbell M. D.

Sept 9 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 10 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E North

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56814

D 56814

X 51

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore.

CITY OF BALTIMORE: No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jennie Eyler

(a) RESIDENCE. NO. Linwood Md ST., WARD Linwood Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ John N. Eyler

6 DATE OF BIRTH (month, day, and year) July 18,

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Geo Starr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Fenway.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospital Records

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1921, to Sept 9, 1921, that I last saw her alive on Sept 9, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Thyrotoxicosis following a Thyroidectomy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exophalmic Goitre.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 2, 1921

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) W. W. Jones M. D.

Sept 9 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hunters Creek Carroll Co Md

DATE OF BURIAL Sept 20 1921

20 UNDERTAKER William Cook

ADDRESS 502 E Mad

CAUSE OF DEATH. See instructions on back. TION is very important.

D 56815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56815

1PLACE OF DEATH

CITY OF BALTIMORE (No. 235 S. Charles St. (Charles) 14 WARD)

2FULL NAME Eli Mackey

(Residence in Baltimore: No. 705 Fraser St. 35 St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, (Month) Unknown, (Day) (Year) 1886.

7-AGE 55 yrs. 5 mos. 5 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country), Jacksonville Fla

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sidney Bradley

(Address) 705 Fraser St.

15- SEP 10 1921

Filed ..... 191.... BOBERT J. KRAUTER

Burial Permit Issued Registrar.

CAUSE OF DEATH to be filled in plainly and completely. Use no abbreviations or unusual terms. Consult physician if necessary. Statements of fact are important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Sept (Day) 7, (Year) 21, 1921

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Neck & Accidental Shock by Electricity

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner)

Sept 9, 1921 (Address) 1027 E 25

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem

DATE OF BURIAL, Sept 11 1921

20-UNDERTAKER, Saml J Kennedy

ADDRESS 775 Park St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37 D 56816

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ____ St.: ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Carr

(a) RESIDENCE. No. 306 S Spring St., ____ Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yr mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bay View Hospital Balto, Md.

15 Filed SEP 10 1921 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8. 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23 1921 to Sept 8 1921
that I last saw him alive on Sept 8, 1921 and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Lueta Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lueta Infection.

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Surgical

(Signed) H. E. Lemmert M. D.

(Address) Bay View Hospital 9/9/1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Sept 11 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

ROBERT J. KILLIAN
Registrar
Burial Permit Clerk

TION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

Jeanne S. Jay.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56817

REGISTERED NO. C 19 D 56817

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Ave (Washington) St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Jeanne Devers Jay

(Residence in Baltimore: No. South ave (Washington) St.; 68 yrs., mos. ds.) in Baltimore

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	widowed

6-DATE OF BIRTH, ?, ?, 1853 (Month) (Day) (Year)

7-AGE, 68 yrs. abt mos. dys. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Wm Rush Devers

11-BIRTHPLACE OF FATHER (State or Country). Frederick Co Va

12-MAIDEN NAME OF MOTHER Emily Humphreys

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel P. Jay

(Address) Mt Washington Balto

15- SEP 10 1921 ROBERT J. REUTER Registrar

Filed ..... 191.... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH September 8, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Sept 8 1921, that I saw her alive on Sept 8 1921, and that death occurred, on the date stated above, at 8.15 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

No known (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Enlarged heart

(Duration) 2 yrs. mos. ds.

(Signed) William S. Todd M. D.

9-9, 1921. (Address) Mt Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. dys.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	Sept 10, 1921
20-UNDERTAKER Henry H. Jenkins Sons Co	ADDRESS Eutaw & McCulloh Sts

Important. See instructions on back of certificate

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56818

CERTIFICATE OF DEATH.

8-09

D 56818

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 Grindall St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Quanito Q. Sheckels

(a) RESIDENCE. NO. 235 Grindall St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 11th 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Fletcher J. Sheckels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Edith V. Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co., Md.

14 Informant Fletcher J. Sheckels
(Address) 235 Grindall St.

15 Filed SEP 10 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

CAUSE OF DEATH to be filled in plain terms. See instructions on back of certificates. THION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20 1921, to Sept. 9 1921, that I last saw h— alive on Aug. 30 1921, and that death occurred, on the date stated above, at 12.30 Noon

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. D. Eggard, M. D.

9/9/1921 (Address) 423 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	Sept 10th 1921

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 56819 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ 63-001 D 56819

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Nursery & Child's Hospital — REGISTERED NO.....

CITY OF BALTIMORE: (No. Franklin & Schroeder ST. 5 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorraine Marlow —

(a) RESIDENCE. No. Nursery & Child's Hosp — ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed or Divorced~~ (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 20-20.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
♯	1		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Franklin Sq. Hosp — Balto, Md.

PARENTS

10 NAME OF FATHER Scott Marlow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ella Marlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Miss. Georgie A. Hutton
(Address) W. C. & Hospital.

15 Filed SEP 10 1921 [illegible] Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1921.

17

I HEREBY CERTIFY, That I attended deceased from Aug. 21 — , 1921, to Sept — 8, 1921, that I last saw h~~er~~ alive on Sept. 7 , 1921, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis —

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis?

(Signed) Emil Stein Jr. M. D.

, 19 (Address) 1006 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 10 1921

20 UNDERTAKER George J. Smith ADDRESS 1000 E Fayette

CAUSE OF DEATH. TION is very important. See instructions on back

Spec.—4-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56820

CERTIFICATE OF DEATH.

73 D 56820

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3015 Garrison Boulevard St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Lena Kingsbury

(Residence in Baltimore: No. 3015 Garrison Boulevard St.: 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~SINGLE,~~ ~~MARRIED,~~ WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, April 16 (Month) (Day), 1854 (Year)

7-AGE, 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~.....~~ None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ga

PARENTS.

10-NAME OF FATHER, Edward Brewer

11-BIRTHPLACE OF FATHER (State or Country), Ga

12-MAIDEN NAME OF MOTHER Carrie E. Jones

13-BIRTHPLACE OF MOTHER (State or Country), Ga

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Brewer

(Address) 3015 Edison Blvd.

15- ROBERT J. KRAUTER

Filed SEP 10 1921, 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 6 1921, to Sept 8 1921, that I saw h[illegible] alive on Sept 7 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Cerebral congestion

(Duration) yrs. mos. 5 ds.

(Signed) Bernard Purdy Brown M. D.

Sept 10, 1921 (Address) 103 W. Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cem DATE OF BURIAL, Sept 10, 1921

20-UNDERTAKER Chas. E. Franck ADDRESS 802 Madison Av

CAUSES OF DEATH. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56821

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56821

CERTIFICATE OF DEATH.

REGISTERED NO. X/31

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Nicholson

(a) RESIDENCE. NO. 1327 Newton St. ST., WARD.
(Usual place of abode) Washington D.C. (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Bryan Nicholson

6 DATE OF BIRTH (month, day, and year) June 15-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	2.	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Octavious Coy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Cora Cowart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Bryan Nicholson
(Address) 1830 E. North Ave

15 Filed ....., 19..... Registrar

SEP 10 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-9 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept-7, 1921, to Sept-9, 1921, that I last saw her alive on Sept-9, 1921, and that death occurred, on the date stated above, at 6.50 P.M.

The CAUSE OF DEATH* was as follows:

Ovarian Cyst.

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Post Operative Hemorrage (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 9-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bryan J. Horine, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem	9/12 1921

20 UNDERTAKER David Sondheim ADDRESS 118 W Mt Royal Ave

TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56822

CERTIFICATE OF DEATH.

D 56822

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cloverdale Apts ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Ruben Stern

(a) RESIDENCE. NO. Charnwood & Linden Aves. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert S. Stern

6 DATE OF BIRTH (month, day, and year) Jan 8/1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jacob Ruben

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Stern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs I. Stern
(Address) Cloverdale Apts

15 Filed . 19 ROBERT I. KRAUTER Registrar

SEP 10 1924 Burial Permit Issued

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9 . 1924 . to Sept 10 . 1924 .

that I last saw h alive on Sept 9 . 1924 .

and that death occurred, on the date stated above, at 2. a. m.

The CAUSE OF DEATH* was as follows: Dbr

Cardiac dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arter. sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. Strassburger M. D.

. 19 (Address) 920 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chev Shalom

DATE OF BURIAL 9/12 192

20 UNDERTAKER Hand Sondheim

ADDRESS 118 N Arch St

...STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage
old
Mitral trouble

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56823

D 56823

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Yee Wing

(a) RESIDENCE. NO. 201 W. Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Yellow	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundryman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) California

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant (Address) Yee Ott 231 Park ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept., 7 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1921, to Sept. 7, 1921, that I last saw him alive on Sept. 7, 1921, and that death occurred, on the date stated above, at 1.15 p m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pleuresy with effussion.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frances L. Badaglacca M. D.

. 19 (Address) Municipal T.B. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL Sept 12 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W Fayette

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous.
No further history.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D 56824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D 56824

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 Cathedral ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert King Wilson

(a) RESIDENCE. NO. 1019 Cathedral ST., 11 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? 73 yrs. 9 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Nov-30-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 100

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Robert Y. Wilson

11 BIRTHPLACE OF FATHER (city or town) Chester Co. (State or country) Penna

12 MAIDEN NAME OF MOTHER Mary J. Appold

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mr Saml Y. Wilson (Brother)

(Address) 1019 Cathedral Street

15 Filed SEP 10 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 12 . 1921 . to Sept 8 . 1921 . that I last saw him alive on Sept 8 . 1921 . and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart Disease

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas W. Dorsett, M. D.

9/9. 1921 (Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemy — DATE OF BURIAL Sept. 12/1921

20 UNDERTAKER STEWART & MOWEN COMPANY (Licensed M. F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

Burial Permit Issued

THION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56825

CERTIFICATE OF DEATH.

79 D 56825

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 N. Bethel ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mustaugh

(a) RESIDENCE NO. 228 N. Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 19 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fairfax Co.
(State or country)

PARENTS

10 NAME OF FATHER Andrew Mustaugh

11 BIRTHPLACE OF FATHER (city or town) Ireland.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Mullholand

13 BIRTHPLACE OF MOTHER (city or town) Ireland.
(State or country)

14 Informant Mary A. McKinley
(Address) 228 N Bethel

15 Filed , 19 Registrar

SEP 10 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1921. to Sept. 8, 1921.

that I last saw her alive on Sept. 8, 1921

and that death occurred, on the date stated above, at 8-55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

9-9-1921 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross DATE OF BURIAL 9-12-1921

20 UNDERTAKER J. J. Moran ADDRESS 300 E. Baltimore St.

CAUSE OF DEATH in plain terms. See back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56826 **CERTIFICATE OF DEATH.** X 104D 56826

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Arlington av ST.) 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. F. Lawton Bowerman

(Residence in Baltimore: No. 706 Arlington av St.; .....yrs.. ...mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... December 13, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Defiance
(b) General nature of industry, business, or establishment in which employed (or employer)..... Pub

9-BIRTHPLACE, (State or Country). Penna

PARENTS.

10-NAME OF FATHER. Geo F. Bowerman

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Mabel Hopkins

13-BIRTHPLACE OF MOTHER (State or Country). Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. F. Bowerman

(Address) 2223 N. Patterson pk. Ave.

15-

Filed ..... 191.....
Registrar.

ROBERT J. KRAUTER
SEP 10 1921
BUREAU OF RECORDS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept 9 ....., 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Sept 9 1921, that I saw him alive on Sept 9 1921, and that death occurred, on the date stated above, at 11:45 p m.

The CAUSE OF DEATH* was as follows:

..... Acute Gastro Enteritis .....

..... (Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) Superficial Abscess of Scrotum

..... (Duration) .....yrs. .....mos. 10 ds.

(Signed) ..... John D. Tenly ..... M. D.

9/10/21 (Address) 3528 Greenmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death .....yrs. .....mos. 12 ds. In the State .....yrs. .....mos. 12 ds.

Where was disease contracted, if not at place of death? Phila Pa.

Former or usual residence Phila Pa.

19-PLACE OF BURIAL, OR REMOVAL. Woodlawn DATE OF BURIAL, Sept 12, 1921

20-UNDERTAKER W. P. Cook ADDRESS 522 E Balto

important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56827

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George. Hall

(a) RESIDENCE. No. Phila. Travelers "Prairie Flyer" ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Hall

6 DATE OF BIRTH (month, day, and year) Aug 1 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37.	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager of a "Prairie Flyer"

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER William Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mc Cann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Hospital Record (Address) Mercy Hospital

15 Filed SEP 10 1921 19 ROBERT J. BRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1921, to Sept 9, 1921, that I last saw him alive on Sept 9, 1921, and that death occurred, on the date stated above, at 6-23 P. m.

The CAUSE OF DEATH* was as follows:

1 Typhoid fever.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Perforated ulcer + Peritonitis (duration) yrs. mos. 3. ds.

18 Where was disease contracted If not at place of death? C

Did an operation precede death? Yes. Date of 9-6-21.

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) D. J. O'Shaughnessy, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St Vincents Cem 9/10/21 19

20 UNDERTAKER Geo G Tinley ADDRESS Fulton & Laytte

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56828

CERTIFICATE OF DEATH.

D 56828

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 118 S Arlington ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M Bayer

(a) RESIDENCE. No. 118 S Arlington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 5 1897

7 AGE: Years 23 Months 10 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 067

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph G Bayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cecilia Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs Anna Bayer 118 S Arlington

15 Filed SEP 10 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9. 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1. 1919. to Sept 9. 1921.

that I last saw him alive on Sept 8. 1921.

and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pul Tuberculosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. O'Neill M. D.

9/10. 1921 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem.

DATE OF BURIAL 9/12/21

20 UNDERTAKER George A Farley Fulton & Dayton

ADDRESS

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56829

150 D 56829

CERTIFICATE OF DEATH.

D 56829

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hughes

(a) RESIDENCE. (Usual place of abode) No. 2610 Bruce Terrace ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 24-1921

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James Hughes

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mamie Shippard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant James Hughes.
(Address) 2610 Bruce Terrace

15 Filed SEP 10 1921, 19.. Registrar

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 3, 1921, to Sept 8, 1921, that I last saw him alive on Sept 8, 1921, and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial thrombosis

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) F A Halden M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 10 1921

20 UNDERTAKER	ADDRESS
W M Cook	502 E. Monument

c.—6-9-19—H. P. Co.—1000 Blks.

Childs D 56830

HEALTH DEPARTMENT—CITY OF BALTIMORE

56830

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

REGISTERED NO.

TY OF BALTIMORE: (No. University Hospital 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Childs

(a) RESIDENCE. No. 1000 Union St., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hester childs

6 DATE OF BIRTH (month, day, and year): Dec. 9-1859

7 AGE — Years: 61 — Months: 9 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thos. Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: R. F. Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: S. Hester Childs

(Address): 1000 Union Ave

15 Filed SEP 10 1921, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1921, to Sept 9, 1921, that I last saw h. alive on Sept 9, 1921, and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 1, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Arley McCoy, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Sept. 12 1921

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 463 Fallsd.

ALBERT J. KOESTER
Burial Permit Clerk

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 D 56831

REGISTERED NO. 14 D 56831

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Shamblin

(a) RESIDENCE. No. 616 Cantrell Ave ST., WARD.
(Usual place of abode) Charleston W Va (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Jessie Shamblin

6 DATE OF BIRTH (month, day, and year) March 26 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	5	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER John W Shamblin

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Nora Baggerly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant (Address) J. H. Hospital Records

15 Filed SEP 10 1921, 19 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 - 1921

17 I HEREBY CERTIFY, That I attended deceased from June 20 - 1921. to Sept 10 - 1921.
that I last saw h[illegible] alive on Sept 10 - 1921.
and that death occurred, on the date stated above, at 8 45 a m.
The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. 10 mos. 5 ds.

CONTRIBUTORY (Secondary) None.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? W. Va.
Did an operation precede death? yes Date of 9/9/21
Was there an autopsy? yes
What test confirmed diagnosis? Microscopic findings.
(Signed) Jay W. DeRay, Johns Hopkins Hospital, M. D.
9/10, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charleston W Va — DATE OF BURIAL: 9/10/21

20 UNDERTAKER: H. E. Hughes — ADDRESS: 424 N. Broadway

CAUSE OF DEATH. See instructions on back of certificate. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56832

56832

56832

CERTIFICATE OF DEATH.

1132899 A

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 N. Castle ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Krug

(a) RESIDENCE. NO. 10 N. Castle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 18, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Krug.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Anna M. Richl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Minnie Feinstein

(Address) 210 S. Castle st.

15 Filed , 19 Robert P. Garrison, Registrar

Burial Permit Clerk.

11521

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1921, to Sept. 8, 1921, that I last saw her alive on Sept. 8, 1921, and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Cancer

(duration) yrs. 1 mos. ds.

18 Where was disease contracted? If not at place of death? e

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. Whitelaw, M. D.

, 1921 (Address) 2504 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 10 1921
20 UNDERTAKER J. S. J. Herr	ADDRESS 154 N. Luzerne ave.

CAUSE OF DEATH. See instructions on back of certificates. ATTENTION is very important.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56833

D 56833

CERTIFICATE OF DEATH.

6 X 63

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO.....

CITY OF BALTIMORE: (No. 120-6 N. Broadway ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Gertrude Young

(a) RESIDENCE. No. Havre de Gras Md. ST., WARD. Havre de Grace Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A. Young

6 DATE OF BIRTH (month, day, and year) Nov. 7th 1881

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Stafford
(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Sheridan

11 BIRTHPLACE OF FATHER (city or town) Stafford
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Gallion

13 BIRTHPLACE OF MOTHER (city or town) Level
(State or country) Maryland

14 Informant Mary E. Hughes
(Address) Havre-de-Gras Maryland.

15 Filed SEP 11 1921 19 Robert I. Harrison, Registrar
Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1921, to Sept 9, 1921, that I last saw h.. alive on Sept 9, 1921, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Intra Medullary tumor of Spinal Cord - (Thoracic Region)

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Havre-de-Gras Md.

Did an operation precede death? Yes Date of June 6-1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. D. Noble, M. D.

19 (Address) Church Home & Inf.y

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rockgrun Harford Co	9/11 1924
20 UNDERTAKER	ADDRESS
Bennowitz & Son	340 Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56834

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56834

CERTIFICATE OF DEATH.

91 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 605 W. 33rd ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Alice Sterner

(a) RESIDENCE. NO. 605 W. 33rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 18 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Alfred L. Sterner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mabel Broyles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Alfred Sterner 605 W. 33rd St

15 Filed 9/11, 1921 Robert F. Harrison, Registrar

SEP 11 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 9, 1921, that I last saw her alive on Sept 9, 1921, and that death occurred, on the date stated above, at 6 50 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Teething

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? clinical

(Signed) Howard Huff, M. D.

9/11, 1921 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	9/12 1921
20 UNDERTAKER Demuth & Son	ADDRESS Baltimore

CAUSE OF DEATH. See instructions on back. IT IS VERY important.

D 56835

D 56835

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 V

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Boyd ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Briscoe

(a) RESIDENCE. NO. 919 Boyd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Elizabeth Briscoe

6 DATE OF BIRTH (month, day, and year) Unknown 1818

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) N.H.D.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary E Briscoe (Address) 919 Boyd St

15 Filed 19 Registrar Robert F. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1921

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to Sept 8, 1921, that I last saw him alive on Sept. 7, 1921, and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Lenthosis Lorar

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Hans Wagner M. D.

Sept 10, 1921 (Address) 1906 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Sept 11 1921
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

11 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56836

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56836

CERTIFICATE OF DEATH.

REGISTERED NO. 9 146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian E. Kempf

(a) RESIDENCE. NO. 1643 Aisquith ST., WARD. St. Mary's
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Sing.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 13 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Kempf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia A. Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. George Kempf
(Address) 1643 Aisquith St

15 Filed Sept 11 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1921, to Sept 10, 1921, that I last saw h[illegible] alive on Sept 10, 1921, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suppurative mastoiditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Frank C. Mavro, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Sept 13 1921

20 UNDERTAKER Henry Hoen & Son — ADDRESS 1301 E Eager St

CAUSE OF DEATH ... See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56837

D 56837

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH Hebrew Hospital 3 REGISTERED No. C.....

CITY OF BALTIMORE: (No..... ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Schulman

(Residence in Baltimore: No. 14 S. Eutaw St St.; ....yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) S

6-DATE OF BIRTH, Jan (Month) 4 (Day), 1921 (Year)

7-AGE, ...yrs. 9 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Kopel Schulman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Annie Bramiskoff

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis

(Address) 1411 E Baltimore

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) / 10 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 8/25 1921, to 9/10 1921, that I saw h er alive on 9/10 1921, and that death occurred, on the date stated above, at 1 10 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY.....
(Secondary)

(Duration)....1 yr.....mos.....ds.

(Signed) Charles I. Levy M. D.

9/10/21, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 16 ds. In the State yrs. 9 mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 14 S. Eutaw Balto

19-PLACE OF BURIAL OR REMOVAL, Woodmen Circle

DATE OF BURIAL, 9—11, 1921

20-UNDERTAKER Jack Louis 1411 E Balto St

ADDRESS

Important. See instructions on back of Certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 56838

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D 56838

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hospital St.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Schmulovitz

(Residence in Baltimore: No. 1610 E. Lombard St. St.: 18 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, October (Month) (Day) 1879 (Year)

7-AGE, 41 yrs. mos. da. — If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clothing
(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E. Baltimore

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

P 1102

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1921, to Sept. 9, 1921, that I saw him alive on Sept. 9, 1921, and that death occurred, on the date stated above, at 3.30 P.m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Duration) yrs. 1 mos. 2 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) A. Lewis M. D.

9/9, 1921. (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 da. In the State 18 yrs. mos. da.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 1610 E. Lombard St

19-PLACE OF BURIAL OR REMOVAL. Workmen circle

DATE OF BURIAL, 9-11, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E. Baltimore St

important. See instructions on back of certificate.

Apoplectic Not Cystic Not Traumatic

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

D 56839 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 56839

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH. REGISTERED NO. C

CITY OF BALTIMORE (No. Mercy Hospital St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Goldstein

(Residence in Baltimore: No. 1064 Granby Street St.: Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Oct 11, 1920
(Month) (Day) (Year)

7-AGE, ..yrs. 11 mos. ..ds.

If LESS than 1 day, ..hrs. or ..min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Jacob Goldstein

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Sarah Hertzen

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balto St

15-

Filed Sept 1 1921 Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.. (Inquest, autopsy or inquiry.) ..find that said deceased came to ..death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Intestines

..1 yr (Duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) None

..(Duration) ..yrs. ..mos. ..ds.

(Signed) ..M. D.
(Coroner.)

Sept 10, 1921 (Address) 1411 E Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1064 Granby St.

19-PLACE OF BURIAL OR REMOVAL. Hebrew Int Assoc

DATE OF BURIAL, Sept 11 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

CAUSE OF DEATH to be filled in plainly and important. See instructions on back of certificate.

P 1 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56840 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56840

CERTIFICATE OF DEATH.

91-079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.: 1 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Shoemaker

(a) RESIDENCE. NO. 3116 Dillon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan 30-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md

PARENTS

10 NAME OF FATHER Adam Burall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co. Md.

12 MAIDEN NAME OF MOTHER Charlotte Wilker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Geo W. Shoemaker (Address) 3116 Dillon St

15 Filed 1 1 1921 Robert P. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9—9 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 25 1921, to Sept 9 1921, that I last saw h r alive on Sept 9 1921, and that death occurred, on the date stated above, at 3.10 P.m.

The CAUSE OF DEATH* was as follows: Cardiac Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? H O Wilson

(Signed) H O Wilson, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Locust Grove Md DATE OF BURIAL Sept 14 1921.

20 UNDERTAKER William Cook ADDRESS 502 E 1[illegible]

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56841

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56841

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N. Castle ST.: 6 WARD)

2-FULL NAME August L. Bures

(a) RESIDENCE. NO. 424 N. Castle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Ferdinand C. Bures

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Musil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant (Address) Ferd. C. Bures 424 N. Castle

15 Filed Robert P. Harrison, Registrar

SEP 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1921, to Sept 10, 1921, that I last saw h... alive on Sept 10, 1921, and that death occurred, on the date stated above, at 11:15 A m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis 4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Cook, M. D.

9/10/21 (Address) 413 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Sept 12 1921

20 UNDERTAKER Philip Henry ADDRESS 2016 Orleans St

CAUSES OF DEATH. See instructions on back of certificate. THIS is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56842 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56842

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1210 Mosher ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Wheeler

(Residence in Baltimore: No. 1210 Mosher St. 35 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	white	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1863 (Year)

7-AGE, 58 yrs. ... mos. ... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): 009

9-BIRTHPLACE, (State or Country), Catonsville Md

PARENTS.

10-NAME OF FATHER, John Wheeler

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Clare

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah E. Wheeler

(Address) 1210 Mosher St.

15- Filed SEP 13 1921, 191... Robert F. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept. (Month) 10th (Day), 192 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 30th 1921, to Sept 10th 1921, that I saw him alive on Sept 7th 1921, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. D. Lightner M. D.

9-10, 1921. (Address) 211 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Sept. 13, 1921
20-UNDERTAKER	ADDRESS
Martin Fahey Jr. Sons	827 W. Lanvale St.

important. See instructions on back of certificate.

D 56843

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79

D 56843

REGISTERED NO. C

PLACE OF DEATH 9. Whitmore Ave.

CITY OF BALTIMORE (No. Valleystille ST.: 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Kate Elgert

(Residence in Baltimore: No. Valleystille St.: 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-~~SINGLE~~, MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)
Female	White	Married

6-DATE OF BIRTH ..... (Month) ..... (Day), 185[illegible] (Year)

7-AGE 67 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE (State or country) Germany

PARENTS

10-NAME OF FATHER Franck Hellemann

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Marie Hellemann

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Elgert

(Address) Valleystille

15- Robert P. Harrison, Filed ..... 191 ..... Burial Permit Clerk REGISTRAR

P 11 1927

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept. 9th (Month) (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. ..... 1926, to. Sept 9th 1927, that I saw h[illegible] alive on ..... 191 . and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Tubular Heart Lesion

I treated him (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Nephritis (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Frank Murray M. D.

SEPT 11, 1927 (Address) 150 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Loudon Park Cem. | DATE OF BURIAL Sept 12 1927

20-UNDERTAKER W. J. Tuckey Sons | ADDRESS Gwynn Oak

B.-Every item of information must be given if possible. Do not state CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of informant is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56844

D 56844

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2018 Westwood Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella Phillips

(a) RESIDENCE. No. 2018 Westwood Ave ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William T. Phillips

6 DATE OF BIRTH (month, day, and year) Sept 30 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elemerias Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John M. Whayland
Address 2018 Westwood Ave

15 Filed Robert F. Harrison, Registrar

1 1 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Sept 10 21, 19

that I last saw h[illegible] alive on Sept 9 21, 19

and that death occurred, on the date stated above, at 11-45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

About 2 yr Dr Stirling ds.
(duration)

CONTRIBUTORY (Secondary) Cardiac Arteriosclerosis mos. Sudden ds.
(duration)

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. G. Stewart M. D.

(Address) 1914 Monument

Sept 10 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Allen Md	Sept 12 19 21

20 UNDERTAKER Joseph Lyter ADDRESS 1600 W North Ave

TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 lfks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56845

D 56845

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 Rockhill Terrace ST., 9 WARD) —

2-FULL NAME Bertha M Foster

(a) RESIDENCE NO. 520 Rockhill Terrace ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Albert W Foster.

6 DATE OF BIRTH (month, day, and year) Feb 8/1896.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Wm Conley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Violet Dieketts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Albert W Foster (Address) 520 Rockhill Terrace

15 Filed ..., 19 Registrar Robert F. Harrison.

11 1921 Via Brooks. C/o albert w foster

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1921

17 I HEREBY CERTIFY, That I attended deceased from About 2/10, 19..., to Sept 10, 1921.

that I last saw her alive on Sept 10, 1921

and that death occurred, on the date stated above, at 12 - m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. G. Dentler, M. D.

, 19 (Address) 634 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: March Church Pa — DATE OF BURIAL: Sept 12/21

20 UNDERTAKER: Wm Cook. — ADDRESS: 502 E Hoffman Av

C/o albert w foster

CAUSE OF DEATH to plainly written. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56846

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56846

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S. Schroeder St. 18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie M. Dayle

(a) RESIDENCE. No. 19 S. Schroeder St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of Wm. J. Dayle,

6 DATE OF BIRTH (month, day, and year) Aug 23, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Patrick Fagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) John Dayle 1001 Hilldrup St.

15 Filed SEP 11 1921, 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1921, to Sept. 9, 1921, that I last saw her alive on Sept. 9, 1921, and that death occurred, on the date stated above, at 7.30 A.m.

The CAUSE OF DEATH* was as follows:

Mastriditis 000

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Streptococcic Septicaemia

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? YES Date of March 1921

Was there an autopsy? NO

What test confirmed diagnosis? Operation & blood culture

(Signed) J. T. Hennessy, M. D.

, 19 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
New Cathedral	Sept 13 1921
20 UNDERTAKER Geo W Little	ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH ... TION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Originally started with grip.
No accident Not
tuberculous.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56847

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56847

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. 1200 Mosher ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Snyder

(a) RESIDENCE. NO. 1200 Mosher ST., ... WARD.

(Usual place of abode) whole life

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Jennie Snyder

6 DATE OF BIRTH (month, day, and year) June 4 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Benjamin Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Miss. Gertrude Snyder (Address) 1200 Mosher St

15 Filed Sep 11 1921 Robert L. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1921, to Sept. 9, 1921, that I last saw him alive on Sept. 8, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Chas. T. McCarthy, M. D.

Sept. 1921 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park — DATE OF BURIAL Sept 12 1921

20 UNDERTAKER Geo W Little — ADDRESS 2700 Edmondson Av

D 56848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169 D 56848

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Riverview Balto. WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick L. Barrett

(Residence in Baltimore: No. 1623 E. Lanvale St. St. 11 yrs., — mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Single

6-DATE OF BIRTH, August 25, 1910 (Month) (Day) (Year)

7-AGE, 11 yrs. — mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Harry K. Barrett

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Frances A Mauley

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry K. Barrett

(Address) 1623 E. Lanvale St.

15-

Filed ....., 191.... Robert P. Harrison Registrar.

SEP 11 1921 Burial Permit Clerk.

CAUSE OF DEATH in plain terms. Indefinite answers will not be accepted. Every question must be answered if possible. Omissions will delay burial. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....viewy.... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) ....find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Temporary Permit for Burial.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Sherry Gaus M. D. (Coroner)

9/11, 1921 (Address) 1804 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral

DATE OF BURIAL, Sept 12, 1921

20-UNDERTAKER Wm Cook

ADDRESS 502 E North ave

Accidental Drowning.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D 56849

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56849

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 14 WARD)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hanson

(a) RESIDENCE NO. 206 Woodlawn Road ~~St.~~ WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. 20 / 60 min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Aquilla Braon Hanson

11 BIRTHPLACE OF FATHER (city or town) Harford Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Thos J. Williams

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant A. B. Hanson (Address) 206 Woodlawn Road

15 Filed ... Registrar Robert F. Harrison, M Burial Permit Clerk.

CAUSE OF DEATH to be plainly written. DO NOT USE ABBREVIATIONS OR SYMBOLS. INFORMATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1921, to — same date, 19 ..., that I last saw h_ alive on Sept 11, 1921, and that death occurred, on the date stated above, at 2:15 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Maternal Toxemia (Nephritis)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D. M. Shiel, M. D.

, 19 (Address) Woman's Hospital Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Sept 12, 1921

20 UNDERTAKER: Lewis W Jenkinson Co

ADDRESS: Eastern Ave & Pulaski St

SEP 11 1921

D 56850 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56850

CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH: Pronounced Dead at South Bully Emergency Hospital

CITY OF BALTIMORE (No. Brooklyn A. A. Co. Md. St.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Ira O. Bradburn.

(Residence in Baltimore: No. 884 W. Lombard St.

St.: 24 yrs., 9 mos. 20 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. November 19th. 1896, (Month) / (Day) / (Year)

7-AGE. 24 yrs. 9 mos. 20 da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffeur.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Samuel R. Bradburn.

11-BIRTHPLACE OF FATHER (State or Country). Washington, D. C.

12-MAIDEN NAME OF MOTHER. Ella V. Crooks.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Neff C. Bradburn, (brother)

(Address) 2564 W. Fayette St.

15- Robert F. Harrison,

1921, 191.... Burial Permit Clerk. Registrar.

11 1921

CAUSE OF DEATH to be filled in plain terms. Every item important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 8th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage due to a pistol shot wound in the left chest (Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Homicide (Duration) ....yrs. ....mos. ....da.

(Signed) Otto M. Kinmax M. D. (Coroner.)

Sept. 10, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. John J. Gowan Son — DATE OF BURIAL. Sept. 12 1921

20-UNDERTAKER London Park — ADDRESS 901 Fallsway

Spec. 6-9-19 H. P. C. 1000 Bks.

150 306 ✓ 56851 D 56851 ✓ 176 ✓ 56851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lowman

(a) RESIDENCE NO. 105 South St. Johnstown ST., Pa. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos 12 ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Widowed.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of †

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Samuel Lowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Elizabeth McClain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

11 Informant (Address) Johns Hopkins Hospital Records

15 Filed SEP 12 1921 19 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 30 . 1921 . to Sept 11 . 1921 .

that I last saw h alive on Sept. 11 . 1921 .

and that death occurred, on the date stated above, at 450 a m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic hypertrophy

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post operative Hemorrhage.

(duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/7/21

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Eugene C Shaw . M. D.

9/11, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnstown Pa

DATE OF BURIAL Sept 12 19 21

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 N Bway

Check of certificates. See instructions on back of CERTIFICATE. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Helen R. S. Gough.

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D 56852

CERTIFICATE OF DEATH.

D 56852

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 Wilson St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen R Smith Gough

(a) RESIDENCE. NO. 539 E Wilson St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct - 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) — 837

(c) Name of employer Bacco

9 BIRTHPLACE (city or town) (State or country) Grow Smith Co Ind.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co Md.

12 MAIDEN NAME OF MOTHER Mary Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14 Informant Joseph F. Smith (Address) 2264 Druid Hill Ave

15 Filed SEP 12 1921 Registrar

Burial permit 0 Clock

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 10, 1921, that I last saw h[illegible] alive on Sept 9, 1921 and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Abscess of the Front

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bright's Disease (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. McGinnis M. D.

, 19 (Address) 1303 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Sept 12 21

20 UNDERTAKER David Easton

ADDRESS 916 Eutaw

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Elvin Himmelhaber

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56853

D 56853

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 2429 E Lager Place ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elvin Himmelhaber

(a) RESIDENCE. NO. 2429 Lager Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 28 1918

7 AGE: Years 3 Months 7 Days 14 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Henry Himmelhaber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Ethel Lenhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant (Address): Henry Himmelhaber 2429 Lager Place

15 Filed, SEP 12 1921, 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 2 1921, to Sept 11, 1921, that I last saw him alive on Sept 11, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Diphtheria, Tonsillar Pharyngeal

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? do not know

Did an operation precede death? ..... Date of .....

Was there an autopsy? No Culture positive negative

What test confirmed diagnosis?

(Signed) R. J. Hardy M. D.

9/11/1921 (Address) 1202 N Edw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: Sept 12 1921

20 UNDERTAKER: Ernest Brack & Son — ADDRESS: 1116 Eastern Ave

INSTRUCTION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56854

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 56854

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1004 W Balto ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Royston Paul Jones

(a) RESIDENCE. NO. 1004 W. Balto ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred X yrs. 1 mos. 26 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 14, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Royston L. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER LaLaine Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mt Airy Md.

14 Informant (Address) Mrs W. P. Jones 1004 W. Balto.

15 Filed SEP 12 1921 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1921, to Sept 10, 1921, that I last saw him alive on Sept 10, 1921, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) X yrs. X mos. 20 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) John Talbott, M. D.

, 19 (Address) 1053 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL Sept 12 1921

20 UNDERTAKER Geo J Smith

ADDRESS 1000 Fayette

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Enteritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-089 D 56855

D 56855

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 Fort ave ST.: 24 WARD)

2-FULL NAME Mabel Rappold

(a) RESIDENCE. NO. 1632 Fort ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	26	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Rappold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rose Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Robert Rappold.
(Address) 1632 Fort ave

15 Filed SEP 12 1921 Robert J. Krauter Registrar

Burial Permit Sept

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1921, to Sept 10, 1921, that I last saw h[illegible] alive on Sept 10, 1921, and that death occurred, on the date stated above, at 7.30 A. m.,

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hanna M. D.

(Address) 18 Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Sept 13 1921

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager

CAUSE OF DEATH. See instructions on back of certificate. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 ✓ D 56856

D 56856

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1444 Block ST.: 3 WARD)

2-FULL NAME Mary C. Scarber

(a) RESIDENCE. NO. 1444 Block ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 15, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer Judd Leser Co

9 BIRTHPLACE (city or town) (State or country) Sheppard Scarber Accomac Co Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co Va

12 MAIDEN NAME OF MOTHER Tena Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Judd Leser Co Va

14 Informant Jennie Brown (Address) 1444 Block St

15 Filed SEP 12 1921 ROBERT J. FRAUTEN Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9/ 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 25th 1920 to Sept 9 1921, that I last saw h alive on Sept 9 1921, and that death occurred, on the date stated above at 9.45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

1 yrs. — mos. — ds.
(duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Regular

What test confirmed diagnosis? W. F. Howard M. D.

(Signed) 9/10 1921 (Address) 119 N Caroline Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Sept 12 1921

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Ashland St

TION is very important. See instructions on back of certificate.

Baby Heyn

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56857

CERTIFICATE OF DEATH.

151 D 56857

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3623 Cedar ave ST.: 43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Heyn

(Residence in Baltimore: No. 3623 Cedar Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR DIVORCED, (Write the word.)
m	White	

6-DATE OF BIRTH, Sept 10, 1921
(Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 0 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Herman L Heyn

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Minnie Bell Hafley

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H L Heyn

(Address) 3623 Cedar Ave

15- SEP 12 1921 [illegible] KRAUTER

Filed ....., 191.... Registrar.

Burial Permit [illegible]

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest and [illegible] find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Ehrmann M. D.
(Coroner)

Sept 12 1921 (Address) 532 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Wiesburg Balto Co

DATE OF BURIAL, Sept 12 1921

UNDERTAKER Chenoweth & Son

ADDRESS Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56858

CERTIFICATE OF DEATH.

D 56858

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1826 W. Saratoga ST.; (2) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hussey

(a) RESIDENCE. NO. 1826 Saratoga ST., 20 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph a Hussey

6 DATE OF BIRTH (month, day, and year) May 1st 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Noah Hilselman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Nancy Hilselman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) H. P. Bash 1826 W Saratoga St

15 Filed SEP 12 1921 ROBERT I. [illegible] Registrar

Burial Permit Sept

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1920, to Sept 9, 1921.

That I last saw h[illegible] alive on Sept 8, 1921.

And that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

DVH

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis, Paralysis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter E. Knickman M. D.

Sept. 12, 1921 (Address) 2002 N. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL. St Pauls Balto County Md. Sept 12 1921

20 UNDERTAKER — ADDRESS H B Wappert 2231 Frederick Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Information in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage.
Chronic nephritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56859

CERTIFICATE OF DEATH.

104 D 56859

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2438 S Charles St. 13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Leonard Estep

(a) RESIDENCE. No. 2438 S Charles St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS

10 NAME OF FATHER Elva H. Estep

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Pearl Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant Elva H. Estep
(Address) 2438 S Charles St

15 SEP 12 1921 BOYER J. KRAUTZ Registrar
Burial Permit Given

TION is very important. See INSTRUCTIONS on the

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1921

17 I HEREBY CERTIFY, That I attended deceased from 9.5 .1921. to 9.11 .1921.

that I last saw h[illegible] alive on 9.11 .1921.

and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Convulsion (duration) yrs mos 7 ds

CONTRIBUTORY (Secondary) Gastro Enteritis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L J Turlington M. D.

9.11 1921 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery Md — DATE OF BURIAL: Sept 12 1921

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light

Stmt.—6-9-19—H. P. Co.—1000 Blks.

60558 HEALTH DEPARTMENT—CITY OF BALTIMORE 63-001 ✓

D 56860 CERTIFICATE OF DEATH. D 56860

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 3 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Winterling.

(a) RESIDENCE. NO. 241 S Bond ST. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17- 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	6	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work chief boo
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Leo Winterling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Bertha Garlough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Johns Hopkins Hospital (Address) Dispensary

15 Filed SEP 12 1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9 . 1921 . to Sept 10 . 1921 . that I last saw h Er alive on Sept. 10 . 1921 . and that death occurred, on the date stated above, at 1.15 p m.

The CAUSE OF DEATH* was as follows:

Acute poliomyelitis

(Respiratory paralysis)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lumbar puncture.

(Signed) Horace G. Stewart . M. D

9/10 . 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Sept. 12 1921

20 UNDERTAKER Lilly & Fuller. ADDRESS 402 S Bond St

TION is very important. See instructions on back

Spmc—6-9-19—H. P. Co.—1000 Bks.

D 56861

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 56861

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) 18 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Agnes Wallace

(a) RESIDENCE. NO. 1031 Edmondson Av. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6th 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland "

12 MAIDEN NAME OF MOTHER M. B. Jordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " Ireland "

14 Informant Miss Monica Wallace

(Address) 1031 Edmondson Ave

15 SEP 12 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-30, 1921, to 9-11, 1921

that I last saw h[illegible] alive on 9-11 1921

and that death occurred, on the date stated above, at 2 20 P. m.

The CAUSE OF DEATH* was as follows:

Chr. nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? chemical

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Sept 13 1921

20 UNDERTAKER Henry Jenkins & Sons Co

ADDRESS Orchard & McCulloh

TION is very important. See instructions on back.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56862

CERTIFICATE OF DEATH.

79 D 56862

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 517 Hargrave al ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Smith

(Residence in Baltimore: No. 517 Hargrave al)

38 St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, June (Month) 1 (Day) (Year)

7-AGE, Under 70 yrs. mos. da.

If LESS than 1 day, hrs. or mtn.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country) born in Burgett Va live in Balt- 38. 79 Years

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Woods

(Address) 1210 Aisquith St

15- SEP 12 1921 Filed ....., 191. Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 9 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Alcoholism Chronic

(Duration) yrs. mos. da.

(Signed) Geo Foley M. D. (Coroner.)

Sept 12, 1921. (Address) 1637 Bonney

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Sept 13, 1921

20-UNDERTAKER, Mrs R A Elliott

ADDRESS 1721 Ashland Ave

Spec.—6-9-10—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56863

CERTIFICATE OF DEATH.

28 D 56863

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Strecker

(a) RESIDENCE. No. 1714 Patapsco st. ST. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S. If of foreign birth Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Strecker

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 631

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Zeberhurt Strecker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Feronic ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records
(Address) M.T.H.

15 Filed SEP 12 1921 ROBERT J. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1919 to Sept. 11 1921.

that I last saw him alive on Sept. 10 1921,

and that death occurred, on the date stated above, at 2.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Clyde McNeil, M. D.

9-11-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Sept 13 1921

UNDERTAKER W. J. & E. Evans Co.

ADDRESS 420 N. Howard St.

TION is very important. See instructions on

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56864 ✓ D 56864

D 56864

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 802 Mangold ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie M. Heffernan

(a) RESIDENCE. No. 802 Mangold ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Heffernan

6 DATE OF BIRTH (month, day, and year) Aug 29 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 027

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jersey City N J

PARENTS

10 NAME OF FATHER Christopher Geraghty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jersey City N J

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

11 Informant Thomas J Heffernan
(Address) 802 Mangold st

15 Filed . 19 Registrar

FORBES & KNAUTH

SEP 12 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921.

17 I HEREBY CERTIFY, That I attended deceased from Sept 9 . 19 19. to Sept 9 . 19 21. that I last saw h[illegible] alive on Sept 9 . 19 21. and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Not Date of

Was there an autopsy? No Sputum

What test confirmed diagnosis?

(Signed) Wm E Schwamb M. D.

. 19 (Address) 1120 W Lewis St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral cemetery	Sept 13 1921.

20 UNDERTAKER James Lignan & Son ADDRESS 1000 S. Pac. St

TION is very important. See instructions on back of cer[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56865

D 56865

CERTIFICATE OF DEATH.

73

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 405 E. Grundal St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Leonard

(a) RESIDENCE. No. 619 N. Bass St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edw. Leonard

6 DATE OF BIRTH (month, day, and year) Oct 20 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Howard Lawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Inman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Edward Leonard

(Address) 405 E. Grundall st

15 Filed SEP 12 1921 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 . 1921 . to Sept 10 . 1921 .

that I last saw her alive on Sept 10 . 1921 .

and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Neuritis

(duration) yrs. mos. 3½ wks ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. Whitehill M. D.

Sept 11. 1921 (Address) 1294 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Sept 13 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 E Pratt

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 56866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56866 ✓

64-091

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH City Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, NO. ..... ST. N WARD)

2-FULL NAME Catherine Fitzpatrick

(a) RESIDENCE. NO..... City Hosp ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unk

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk

14 Informant Hosp. Records (Address)

15 FILED SEP 12 1921 Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11 1921

17 I HEREBY CERTIFY, That I attended deceased from 8-19-1921. to 9-11-1921.

that I last saw her alive on 9-11-1921.

and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde McGrath, M. D.

9-12 1921 (Address) City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	9/13/21 19
20 UNDERTAKER Wm Cook.	ADDRESS 5002 York

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56867

D 56867

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Baltimore ST.: 17 WARD: 6th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Snelling

(a) RESIDENCE. NO. 2114 Barclay St. ST.. WARD. St. A. Ward

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Victoria

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker 086

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer Do not know

9 BIRTHPLACE (city or town) (State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs. Victoria Snelling (Address) 2117 Barclay St.

15 Filed . 19 Registrar

~~Burial Permit Dist~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8- 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-7-, 1921, to 9-10-, 1921, that I last saw him alive on 9-10-, 1921, and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma glands neck.

(duration) — yrs. 15 mos. — ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 7-'21.

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden — DATE OF BURIAL: Sept 13 1921

20 UNDERTAKER: H. H. Holt — ADDRESS: 501 W. Mt. St.

TION is very important. See instructions on back of certificate.

P 1 2 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56868

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH City Hospital. REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... St.; 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levi M. Chaney

(a) RESIDENCE. No. 1824 Aisquith St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Wid.

5a If married, widowed, or divorced HUSBAND) of (or) ~~WIFE~~ of Widow of Louisa Chaney

6 DATE OF BIRTH (month, day, and year) May 17, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Levi M Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ellen S Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Hattie Chaney Daughter
(Address) 1824 Aisquith St

15 Filed ... 19... ... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2 . 1921. to Sep. 11 . 1921.

that I last saw h ~~im~~ alive on Sep. 11 . 1921

and that death occurred, on the date stated above, at 12 35 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill . M. D.

(Address) City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 DATE OF BURIAL, CREMATION, OR REMOVAL Western Cem't

DATE OF BURIAL Sept 14 1921

20 UNDERTAKER Wm Balsley & Nathan

ADDRESS

TION is very important. See instructions on back of certificate.

12 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56869
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

92 D 56869
REGISTERED NO.

CITY OF BALTIMORE: (No 505 W. Cross ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Harrell

(a) RESIDENCE. No. 505 W Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 15 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS
10 NAME OF FATHER Charles Harrell Jr
11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.
12 MAIDEN NAME OF MOTHER Florance Johnson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Shedrick Johnson grandfather
(Address) 505 W cross st

15 SEP 12 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 10, 1921, that I last saw h— alive on Sept 9, 1921, and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows: Pulmonary tb

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? 505 W Cross

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) C. N. Frazier, M. D.

, 1921 Address) 712 S Chapel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn ct	Sept. 13 1921
20 UNDERTAKER	ADDRESS
J. H. Brown and Son	10 S Wmartyn

CAUSE OF DEATH to be filled in by physician. Information on back of certificates. TION is very important. See instructions on back.

Burial permit filed

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56870

CERTIFICATE OF DEATH.

1720 D 56870

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 10 N. Hilton ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard R Uhlig

(Residence in Baltimore: No. 10 N. Hilton St.: 15 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widower

6-DATE OF BIRTH, Aug (Month) 18 (Day), 185[illegible] (Year)

7-AGE 69 yrs. — mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Dr
(b) General nature of industry, business, or establishment in which employed (or employer): Manufacturer

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Richard Uhlig

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fr. Wm R. Uhlig

(Address) 230 N. Payson St

15- Filed SEP 1 2 1921, 191.... ROBERT E KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 10 (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 1, 1920, to Sept 10 1917, that I saw h[illegible] alive on Sept 10 1917, and that death occurred, on the date stated above, at 3P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) 2 yrs. mos. ds.

(Signed) Geo. T. McKee & Son M. D.

Sept 11, 1917, (Address) Monument & Aisquith Sts

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem

DATE OF BURIAL, 9-13-, 1917

20-UNDERTAKER Wm Chas C. G. Rohde

ADDRESS 822 Arlington Ave

Important. See instruction on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56871

CERTIFICATE OF DEATH.

109 D 56871

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Howard a Kelly Hosp 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude V. Ely.

(a) RESIDENCE. No. 3116 Harford Rd. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — John Ely.

6 DATE OF BIRTH (month, day, and year) June 22nd 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry Deemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Lange

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant (Address) J. Wm. Ely 3116 Harford Road.

15 Filed SEP 12 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1921, to Aug 10, 1921, that I last saw h[illegible] alive on Aug 10, 1921 and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows: General peritonitis Following intestinal obstruction

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 8th 21

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Drury A. Robinson, M. D.

, 19 (Address) 418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuel Cemetery	Sept 13 1921
20 UNDERTAKER	ADDRESS
Frank Lassahn & Sons	Fullerton

CAUSE OF DEATH. See instructions on back OF CERTIFICATE

TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56872

CERTIFICATE OF DEATH.

X 9

D 56872

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital St. N Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Campbell

(a) RESIDENCE. No. Rossville P.O. Essex Md. Ward. Rossville Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27 - 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Child

(b) General nature of industry, business, or establishment in which employed (or employer) do do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chase, Md.

PARENTS

10 NAME OF FATHER John Robert Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rossville Balto Co.

12 MAIDEN NAME OF MOTHER Ida Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn Balto. Co

14 Informant John Robert Campbell

(Address) [redacted]

13 Filed 12 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 11th, 1921, to Sept 11, 1921.

that I last saw her alive on Sept 11th, 1921,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diphtheria, pharyngeal and laryngeal.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Intubated Date of Sept 11-1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. C. Martian, M. D.

, 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ozma Cemetery	Sept. 12 1921
20 UNDERTAKER	ADDRESS
Fred'k Lissauer & Sons	Fulerton Md.

TION is very important. See instructions on back of c

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56873

CERTIFICATE OF DEATH.

D 56873

REGISTERED NO. 184

1-PLACE OF DEATH

CITY OF BALTIMORE: NO 1325 Andre. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Jakubowski

(a) RESIDENCE NO. 1325 Andre, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) May 18-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Jakubowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Price.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Jakubowski (Address) 1325 Andre- St

15 Filed [illegible] Registrar

121921

Burial Permit Issued

TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from aug. 28, 1921, to Sept. 10, 1921, that I last saw h ~~im~~ alive on Sept 9, 1921, and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Ills Coarctis.

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1325 Andre St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos F. Flynn, M. D.

9/11, 1921 (Address) 2878 Stafford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Sept 12 1921
20 UNDERTAKER	ADDRESS
Wm Frankowski	1618 Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56874

D 56874

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2932 E.Baltimore ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Drew Gunby

(a) RESIDENCE. No. 2932 E.Baltimore ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch.19.1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steamboat Captain

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: City official

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James Gunby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Maria Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St.Mary's Co. Maryland

14 Informant: Miss Mollie Gunby

(Address): 2932 E.Baltimore St.

15 Filed [illegible] 1921 Registrar

SEP 12 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept.10.1921 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1. 19[illegible], to Sept. 10. 19 21, that I last saw h[illegible] alive on Sept. 9. 19 21, and that death occurred, on the date stated above, at 12:05 A m.

The CAUSE OF DEATH* was as follows:

Senility.

0 DW

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Knott Ingles M. D.

. 19 (Address) 2932 E. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	9-13-21 19

20 UNDERTAKER: H.E.Hughes ADDRESS: 424 N. Broadway

CAUSE OF DEATH should be stated by the physician in plain English—see instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic.

Spec.—1-10-21—M&T—1500 Blks.

D 56875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56875

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 Gutman ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara E. Schofield

(a) RESIDENCE No. 536 Gutman ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Schofield

6 DATE OF BIRTH (month, day and year) Feb 28 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
88				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Ramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Alice Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Alice Schofield

(Address) 536 Gutman ave

15 Filed Sept 10 1921 ROBERT I. KRAFTEN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1921, to Sept 9, 1921,

that I last saw her alive on Sept 9, 1921,

and that death occurred, on the date stated above, at 11 9 m.

The CAUSE OF DEATH* was as follows:

OVER

Pneumonia.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical only

(Signed) W. M. Sanders M. D.

9/11/21 (Address) 321 E 21st

*State the Disease Causing Death, or in deaths from Violent Causes, state: (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Govans DATE OF BURIAL Sept 10 1921

20 UNDERTAKER E. A. Medefield ADDRESS 501 E 20th St

CAUSE OF DEATH in plain words. See instructions on back of certificates. TION is very important.

12 1921 Burial Permit Clerk

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Broncho

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56876 6 D 56876

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 114 N. Vincent ST.: 19 WARD)

2-FULL NAME Henry Johnson

(a) RESIDENCE. No. 114 N. Vincent ST., 19 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work B Boy

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Luther H Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Anna Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Luther H. Johnson
(Address) 114 N. Vincent St

15 Filed [illegible] Registrar

12 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-12 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-10, 1921, to 9-12, 1921, that I last saw h[illegible] alive on 9-11, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia and Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. 1 mos. 00 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diag

(Signed) Walter J Tracy M. D.

. 19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 13th
20 UNDERTAKER	ADDRESS
A. Jones	209 S Stricker St

CAUSE OF DEATH. Physicians are required to fill out the answers to questions on back of certificates. See instructions on back of certificates. ATION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

(See affadavit over)

14943 B 56877

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56877

CERTIFICATE OF DEATH.

174

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.:) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hood

(a) RESIDENCE. No. Petersburg Va St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 22 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 2 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Isaac Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Columbia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Johns Hopkins Hospital, Records (Address)

15 Filed SEP 1 1921 REGISTRAR PUBLIC CEMETERY. Registrar

1 2 1921

TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921

17

I HEREBY CERTIFY, That I attended deceased from July 13 1921 to Sept 9 1921

that I last saw h[illegible] alive on Sept 9 1921

and that death occurred, on the date stated above, at 11 a.m. 9 p.m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

Cerebellar adhesions

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Sept 1

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Camille Holmes, M. D.

9.10. 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Public Cemetery Petersburg Va	SEP 12 1921

20 UNDERTAKER [illegible] ADDRESS [illegible]

[illegible] Health

Baltimore, Md., Sept. 20, 1921.

I do hereby make oath to the following facts concerning Baltimore City Department of Health Death Certificate No. D-56877.

I was engaged by the mother of the deceased,(John Hood,) to prepare the body for burial and to arrange to ship same to Petersburg, Virginia, on Tuesday, for interment. I did this and not hearing from the mother, Columbus Hood, held the body. I heard from her on Friday stating that if she was not in the city, or I had not heard from her by Saturday noon, she would not be able to pay for the shipment and burial of the body and that I should turn same over to Baltimore City for burial.

This I now desire to do and to have changed on said certificate of death, the place of burial, which is recorded as Petersburg, Virginia. Also date of burial, Sept. 1, 1921, and the name and address of the Undertaker - John W. Henderson, 1502 E. Monument Street. Said data on said certificate should now be recorded and

Place of Burial - Public Cemetery.
Date of Burial - September 20th, 1921.
Undertaker - Commissioner of Health.

John W Henderson
Undertaker.

Subscribed and sworn to before me this 20th day of September, 1921.

Reed Gaither
Notary Publ

Spec.—1-10 21—M&T—1500 Bks.

56878 D 56878

HEALTH DEPARTMENT—CITY OF BALTIMORE

56878 D 56878

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 N. Appleton ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Fannie Bicowich

(a) RESIDENCE NO. 1618 N. Appleton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: L. Lewis (Address): 1411 E. Baltimore St.

15 Filed ..... 19 ..... Registrar

SEP 13 1921 Burial Permit Issued

CAUSE OF DEATH: This item must be answered in every case. See instructions on back of certificate. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept, 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug, 25, 1921, to Sept, 12, 1921, that I last saw her alive on Sept, 12, 1921, and that death occurred, on the date stated above, at 2,30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Chr. Endocarditis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Consultation

(Signed) Dan'l Franklin M. D.

9/12 1921 (Address) 1122 N See St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New York, N. Y.

DATE OF BURIAL: Sept 13, 21

20 UNDERTAKER: Jack Lewis, 1411

ADDRESS: E. Balto.

Spec.—6-9-19—H. P. Co.—1000 Bks.

56879 D 56879

HEALTH DEPARTMENT—CITY OF BALTIMORE

56879

CERTIFICATE OF DEATH.

X 120 D 56879

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katie Hardy

(a) RESIDENCE. NO. Westminster Md. ST., ... WARD. Westminster Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles M. Hardy

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE: Years: About 65 — Months — Days — If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westminster Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Chas. M. Hardy Westminster Md.

15 Filed ..... 19 ..... Registrar

ROBERT A. CRUTER

Burial Permit Clerk

SEP 13 1921

CAUSE OF DEATH. Please write plainly. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12. 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11th, 1921, to Sept 12th, 1921.

that I last saw her alive on Sept 12th, 1921.

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Myocardial insufficiency oedema of the lungs. (duration) yrs. mos. 6 hrs.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? no Date of c

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Nestor de Cardenas M. D.

. 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 15 19
20 UNDERTAKER	ADDRESS
H Bankard & Son	Westminster Md

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *22 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

S.D.C.
T.T.H.
Chr. nephritis.

Spec.—1-10-21—M&T—1500 Blks.

D 56880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56880

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1611-Rutland Ave.. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Allwisi

(a) RESIDENCE NO. 1611-Rutland Ave ST.. WARD ....

(Usual place of abode)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John V. Allwisi

6 DATE OF BIRTH (month, day, and year) July 3rd. 1859

7 AGE	Years	Months	Days	If LESS than 1 day ...hrs or ...min.
	62	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bernard J. Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cath. Kruger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Bernard Allwisi 1611-Rutland Ave

15 Filed ..... 19 ROBT. J. KRUTZ Registrar

SEP 13 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5 ..., 1921 ..., to Sept 9 ..., 1921 ..., that I last saw h*er* alive on Sept 9 ..., 1921 ..., and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Valvular Heart Disease

(duration) yrs. 5 mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Fisher M. D.

9/12, 1921 (Address) 1823 N. East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL 9/13/21

20 UNDERTAKER Geo. J. Ruth ADDRESS 1720 Harford Ave.

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56881

105

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Ashburton ST., 15 WARD)

2-FULL NAME N. Gertie Grille.

(a) RESIDENCE. NO 1707 Ashburton ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 3 - 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — None
(b) General nature of industry, business, or establishment in which employed (or employer) — None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) — Md.

PARENTS

10 NAME OF FATHER — Jacob. Miller.

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Pa.

12 MAIDEN NAME OF MOTHER — Mary M. Grow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Md

14 Informant (Address) — Mrs Rose Stoudenburg 707 Ashburton

15 Filed SEP 13 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-9, 1921, to 9-11, 1921, that I last saw her alive on 9-10, 1921, and that death occurred, on the date stated above, at 5:00 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhea. 4 ds.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Cullen M.D.

9/13/21 (Address) 2757 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Westminster Md — DATE OF BURIAL Sept 13 1921

20 UNDERTAKER — F. A. Krause & Son — ADDRESS 703 Hanover

CAUSE OF DEATH. See instructions on back of certificate. THIS is very important.

John W. B. Tweedale

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56882 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56882

CERTIFICATE OF DEATH. 80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Ashburton ST. 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. W B Tweedale

(a) RESIDENCE. No. 1707 Ashburton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabel Tweedale

6 DATE OF BIRTH (month, day, and year) Sept 8-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) #62 Pub ach.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Wm Tweedale

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Isabel Tweedale (Address) 1707 ashburton st

15 Filed SEP 13'1921 BURIAL PERMIT CLERK

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 . 1921 . to Sept 11 . 1921 . that I last saw him alive on Sept 10 . 1921 . and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

Myocarditis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) John B Lemmon, M. D.

Sept 11 '21 (Address) 7122 Pulaski Hgh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Sept 13 1921
20 UNDERTAKER	ADDRESS
F. A. Kranaeoson	743 Hanover

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56883

CERTIFICATE OF DEATH.

120 D 56883

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1707 N. Washington ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert P. Sparks

(a) RESIDENCE. NO. 1707 N. Washington ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie H. Sparks

6 DATE OF BIRTH (month, day, and year) June 6, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	3	3	

8 OCCUPATION OF DECEASED 013

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Sparks Meat Market

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Thos. Sparks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Hattie H. Sparks
(Address) 1707 N. Washington St

15 Filed SEP 13 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1921

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1921, to Sept 9, 1921, that I last saw him alive on Sept 8, 1921, and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Bright Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Org. Heart Disease

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urine Examination

(Signed) James L. Hooper, M. D.

(Address) 3462 28th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 13 1921
20 UNDERTAKER	ADDRESS
A. Vander & Sons	1710 Fleet St

CAUSE OF DEATH in plain terms. Abbreviations not to be used. Omission of certificates. TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56884 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 56884

CERTIFICATE OF DEATH. X 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Saunders, Lennie G.

(a) RESIDENCE. NO. 1014 Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 14 10

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl.

(b) General nature of industry, business, or establishment in which employed (or employer): 600

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Lennie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Minnie Lennie

(Address) 1214 Bolton St. Balto.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 1921, to Sept 12 1921, that I last saw h[er] alive on Sept 12 1921, and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Appendicitis abscess + Ruptured gangrenous appendix

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Peritonitis (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of 9-6-21

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Dr. Finney M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Quantico Va	Sept 13 1921
20 UNDERTAKER	ADDRESS
Samuel Townsend	578 Biddle

mation should be carefully written in ink, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 56885

D 56885

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Savage

(a) RESIDENCE. NO. 536 ~~Lawrence~~ Laurens st. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Elson Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lena Savage

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records M.T.H.

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk

SEP 13 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1 P.M. 21 to Sept. 10. 4.50 P.M. 1921.

that I last saw her alive on Sept. 10 . 1921 .

and that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frances L. Badeglaccar M.D.

9-11-21 (Address) Municipal Tb Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Sept 13 1921

20 UNDERTAKER Samuel T. Hamilton — ADDRESS 578 W Baltimore St

Mt. 7. 2578

CAUSE OF DEATH in plain ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56886

HEALTH DEPARTMENT—CITY OF BALTIMORE D 56886

CERTIFICATE OF DEATH.

REGISTERED NO. 289

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Coles

(a) RESIDENCE. NO. 540 W. Biddle st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of ? Coles
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Charles Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ellen Tydings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records M.T.H. Robert P. Harrison, Burial Permit Clerk

15 Filed SEP 13 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1921, to Sept. 11, 1921, that I last saw her alive on Sept. 10, 1921, and that death occurred, on the date stated above, at 6.10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in Sputum, X-ray

(Signed) Francis L. Dalaglacca M. D.

9-11-21 (Address) Municipal Tb Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Sept 14 1921

20 UNDERTAKER — ADDRESS

Samuel Hemsley 1 W Biddle

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

56887

REGISTERED NO. D 56887

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3129 Fleet St. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Glover

(a) RESIDENCE. No. 3129 Fleet St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of William I. Glover

6 DATE OF BIRTH (month, day, and year) Oct. 9th. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Edward T. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Susan Osmund

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mrs. Chas. D. Nagel 3129 Fleet St.

15 Filed SEP 12 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1921, to Sept 9, 1921, that I last saw her alive on Sept 9, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) Bright's Disease yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? , M. D.

(Signed) adem Tod

9/10, 1921 (Address) 470 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery

DATE OF BURIAL Sept 14 1921

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager St

CAUSE OF DEATH ... TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 56838

56838

CERTIFICATE OF DEATH.

42

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5228 Park Heights ave ST.; 27 WARD)

2-FULL NAME Barbara Eggensperger

(a) RESIDENCE. NO. 5228 Park Heights ST., 27 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 50 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Philip Eggensperger

6 DATE OF BIRTH (month, day, and year) May 4 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) County-Mayo
(State or country) Ireland

PARENTS

10 NAME OF FATHER Michael McCann

11 BIRTHPLACE OF FATHER (city or town) County Mayo
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Dougherty

13 BIRTHPLACE OF MOTHER (city or town) County Mayo
(State or country) Ireland

14 Informant [redacted] Eggensperger-Husband
(Address) 5228 Park Heights Ave

15 Filed [illegible], 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1921

17 I HEREBY CERTIFY, That I attended deceased from April 21- 1921, to Sept 11, 1921, that I last saw h er alive on Sept 11, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus unknown (duration)

CONTRIBUTORY (Secondary) Exhaustion (duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) C A L Emsor, M. D.

, 19 (Address) 5016 Park Hgts ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Sept 14 1921
20 UNDERTAKER [illegible] & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)	ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

56889

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56889

CERTIFICATE OF DEATH.

151 ✓

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2403 Fait Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Davis (If not, how long did he reside in Baltimore? St.; ....yrs.,....mos.....ds.)

(Residence in Baltimore: No. 2403 Fait Ave St.;

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Aug. (Month) 11 (Day), 1921 (Year)

7-AGE, ...yrs. mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None (yet)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Joseph Davis

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Trojanowski

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Davis

(Address) 2403 Fait ave

15- SEP 19 1921

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1921, to Sept 12 1921, that I saw him alive on Sept 11 1921, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Septic Infection

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) Elias D. Mervis M. D.

9/12/21, 191... (Address) 40 & Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, Sept. 13..., 1921

20-UNDERTAKER John M. Weber ADDRESS, 1803 Bank St

important. See instructions on back of certificate.

Premature baby 7½ mos

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

D 56890

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 10 56890

164 Ds. Queens U.S.D.

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 S Robinson ST.; 1-Y WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Linda Rolf

(Residence in Baltimore: No. 314 S Robinson St. 26 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug (Month) 13 (Day), 1895 (Year)

7-AGE, 26 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Saleslady 066
(b) General nature of industry, business, or establishment in which employed (or employer): at Hutzler Bros

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Henry Rolf

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Barbara Ernst

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Barbara Rolf

(Address) 314 S Robinson St.

15- SEP 13 1921

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9th 1921, to Sept 11th 1921, that I saw her alive on Sept 11th 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Ptomaine Poisoning

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Devilled Crab

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Schwatka M. D.

Sept 12th, 1921 (Address) 734 Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, I St Germon — DATE OF BURIAL, Sept 14, 1921.

20-UNDERTAKER Peter Nicolaus — ADDRESS 504 Eastern

important. See instructions on back of certificate.

D 56891

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56891

64

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1112 N. Lafayette Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph F. Broadbent

(Residence in Baltimore: No. 1329 N. Lafayette Ave St.; 53 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	Married

6-DATE OF BIRTH, Oct. 12, 1868
(Month) (Day) (Year)

7-AGE, 53 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joe F. Broadbent

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Jane Dennard

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. L. Roche

(Address) 1112 N. Lafayette Ave

15- Robert F. Harrison,

Filed Sept. 191 Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Jury find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) J. F. Hemmeter M. D.
(Coroner)

Sept 13, 1921 (Address) 2802 Edmondson Ave,

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
New Cathedral	Sept. 14, 1921
20-UNDERTAKER H. C. Brauns & Son	ADDRESS 317 N. Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56892

CERTIFICATE OF DEATH.

D 56892

1-PLACE OF DEATH US.PHS Hosp. #56 Fort McHenry Baltimore Md. REGISTERED NO.

CITY ● BALTIMORE: (NO. Fort McHenry Baltimore Md ST., 3[illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willaim H Rasbury

(a) RESIDENCE NO. US Public Health Hosp. #56 Baltimore Md WARD 30
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER ----

11 BIRTHPLACE OF FATHER (city or town) (State or country) ----

12 MAIDEN NAME OF MOTHER --

13 BIRTHPLACE OF MOTHER (city or town) -- (State or country) -

14 Informant (Address) Edgar T Rosenbrock Registrar US IHS Hosp. #56 Baltimore Md.

15 [illegible] 19 Registrar

CAUSE OF DEATH in plain words. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1921 to Sept. 9, 1921, that I last saw him alive on Sept. 9, 1921, and that death occurred, on the date stated above, at 6'45 p.m.

The CAUSE OF DEATH* was as follows:

Syphilis Geheral.

June 4,/2. (duration) -- yrs -- mos ds.

CONTRIBUTORY (Secondary) Endocarditis chronic.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What tests confirmed diagnosis? Clinic Report

(Signed) Thomas R Payne M. D.

, 19 (Address) Senior Surgeon(R) USPHS #56

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Sept 13 21

20 UNDERTAKER S Penman

ADDRESS E Baltimore

SEP 13 1921

D 56893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X/69 D 56893

REGISTERED NO. C.....

1-PLACE OF DEATH Off Davison's Ferry wharf.

CITY OF BALTIMORE (No. Cabin Branch, Curtis Bay ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John VanNeel.

(Residence in Baltimore: No. Stallings Farm, Curtis Bay. St.: -- yrs., 3 mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH, April 17th. 1921, 1
(Month) (Day) (Year)

7-AGE. ----- yrs. 4 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). England.

PARENTS.

10-NAME OF FATHER. John VanNeel.

11-BIRTHPLACE OF FATHER (State or Country). Holland.

12-MAIDEN NAME OF MOTHER Annie Baker.

13-BIRTHPLACE OF MOTHER (State or Country). England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Annie Baker. (mother)

(Address) Stallings farm, Curtis Bay.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 11th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally drowned by falling from a row boat.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) [signature] (Coroner) M. D.

Sep. 12..., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Cross — DATE OF BURIAL. Sept. 13, 1921

20-UNDERTAKER John Grebliunas — ADDRESS 445 S. Paca St.

CAUSE OF DEATH to be given in plain terms, so that it may be properly important. See instructions on back of certificate.

SEP 13 1921

Spec. 6-9-19—H. P. Co.—1000 Bks.

56894

HEALTH DEPARTMENT—CITY OF BALTIMORE

56894

CERTIFICATE OF DEATH.

170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1203 Whatcoat ST.: 16 WARD)

2-FULL NAME Sarah Reed

(a) RESIDENCE. NO. 1203 Whatcoat ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs — mos — ds. How long in U. S., If of foreign birth? — yrs — mos — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Reed

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
60	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Calvert County Md.

10 NAME OF FATHER Thos. Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 X Informant (Address) Dr Alice Young. 1710 Baker St E.

Filed SEP 13 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1921, to Sept. 9, 1921, that I last saw her alive on Sept. 9, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) John D. Simms, M. D.

9/11, 19 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	9/13 19 21
20 UNDERTAKER	ADDRESS
Edward Fungo & Sons	1463 N Carey

CAUSE OF DEATH must be filled in by physician. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56895

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56895

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Mercy Hospital Balto ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Taylor

(a) RESIDENCE. NO. 805 E. McKim ST. City WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. George Taylor

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~9 18 91~~	30	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: maid

(b) General nature of industry, business, or establishment in which employed (or employer): Maid 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia Balt & steam

PARENTS

10 NAME OF FATHER Jacob Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sally Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Mr Sallie Jones 805 McKim st

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1921

17 I HEREBY CERTIFY, That I attended deceased from August 31 19 , to 9/10 , 19 21.

that I last saw her alive on 9/10 , 19 21.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Bilateral Salpingitis & oophoritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Supra-vag hysterectomy & Drain (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 9/10/21

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) K. W. Stolley, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Sept-13. 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

Copy of certificate. See instructions on back of certificates. TION is very important.

1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 56896

56896

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 303. Glenmyssalley ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna. Sirits

(a) RESIDENCE. NO. 303. Glenmeas 2 ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. ~~Girl~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank. Sirits

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Anna Cella Sirits

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Mary Cella
(Address) 303 Glenmeas Alley

15 ~~BORN~~ ....., 19.....

Registrar

Bur. Permit Issued SEP 13 1921

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1921, to Sept 12, 1921, that I last saw h.. alive on Sept 12, 1921, and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Weinstein M. D.

Sept 12, 1921 (Address) 720 Rutter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Timonds Cem — DATE OF BURIAL: Sept 14 1921

20 UNDERTAKER: Kendall & Lippel & Sons — ADDRESS: 32 Lanvale

Spec. 6-9-19—H. P. Co.—1000 Bks.

1) 56897

HEALTH DEPARTMENT—CITY OF BALTIMORE

1) 56897

CERTIFICATE OF DEATH.

130

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 554 N. Mechanic ST. 14 WARD)

2-FULL NAME Grace Welch

(a) RESIDENCE. NO. 554 N. Mechanic ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alvin Welch

6 DATE OF BIRTH (month, day, and year) Oct. 13, 1857

7 AGE Years 64 Months 6 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Laborer

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Gaunt Welch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Alice Welch (Address) 554 N. Mechanic

15 Filed Sept 13 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1921, to Sept. 10, 1921.

that I last saw h[illegible] alive on Sept. 10, 1921.

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH was as follows:

Bright's Disease.

Interstate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) P. Galvin Schmidt M. D.

Sept 13 1921 (Address) 1534 O. H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Ind. Auburn Cem. Sept 14 1921

20 UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

48 D 56898

CERTIFICATE OF DEATH.

D 56898

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 501 Forest Road, R.P. ST.: 27th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia Pearson

(a) RESIDENCE. NO. 501 Forest Road. ST.: 27th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Pearson

6 DATE OF BIRTH (month, day, and year) Dont Know 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	78	Unknown	Unkn	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 600

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Joseph Farrow

11 BIRTHPLACE OF FATHER (city or town) Dont Know (State or country) Delaware

12 MAIDEN NAME OF MOTHER Mary Dulbrow

13 BIRTHPLACE OF MOTHER (city or town) Dont Know (State or country) Delaware

14 Informant Mrs Catherine Pearson Here (Address) 501 Forest Road R.P.

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept - 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30 1921, to Sept - 12 1921, that I last saw h[illegible] alive on Sept - 11 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis Deformans

(duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Nursing Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M. F. Porter, M. D.

9/12 1921 (Address) 20 and Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Sept 14 1921

20 UNDERTAKER John D Spence

ADDRESS 1325 N. Caroline St

TION is very important. See instructions on back of certificates.

D 56899

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 D 56899

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1130 Hull St. ST. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2 FULL NAME Edmond Clark.

(Residence in Baltimore: No. 1130 Hull St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male.	White	Single

6 DATE OF BIRTH May 17, 1920
(Month) (Day) (Year)

7 AGE 1 yrs. 3 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant 000
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James. Clark.

11 BIRTHPLACE OF FATHER (State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Louis Finn

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louise Clark

(Address) 1130 Hull St.

15. SEP 13 1921, 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 12, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6th, 1921, to. Sept. 12 1921,
that I saw h.. alive on Sept. " 1921
and that death occurred, on the date stated above, at 5 40 a m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 9 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), Thos Fa Stevens M. D.
Sept 12, 1921 (Address) 2878 Harford Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Loudon Park DATE OF BURIAL 9/14, 1921

20 UNDERTAKER J. Collins Lee ADDRESS 1400 W. Lexington St.

A.B.—Every item of information must be given if possible, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56900 ✓ D 56900

CERTIFICATE OF DEATH.

152

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 Wall St ST.: 24 WARD)

2-FULL NAME Robert George Shipley

(a) RESIDENCE. NO. 1231 Wall St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20th 21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Robert Shipley Md

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Victoria Krapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robt Shipley
(Address) 1231 Wall St

15 Filed ..... Registrar

P 13 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12th 1921

17 I HEREBY CERTIFY, That I attended deceased from 8/30/21, 19..., to 9/12/21, 19...

that I last saw him alive on 9/11/21, 19..., and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Infection of Umbilical Cord.

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Brown, M. D.

, 19 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A A Cr	9-13 1921

20 UNDERTAKER E & B Hale ADDRESS 115 Eden St

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56901

CERTIFICATE OF DEATH.

15 29

D 56901

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE (No. 1314 N. Stricker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Whittington

(Residence in Baltimore: No. 1314 N. Stricker St. St.: yrs. 41 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, November (Month) (Day), 1856 (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis Borden

(Address) 1314 N. Stricker St.

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

DEC 13 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Heuisler M. D.
(Coroner.)

Sept 12 1921, (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, Sept. 13, 1921

20-UNDERTAKER James H. Dennis

ADDRESS 1203 Druid Hill Ave.

CAUSE OF DEATH must be filled in. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D 56902

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hogelgans.

(a) RESIDENCE. No. 513 S. Creighton Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced (~~HUSBAND~~) of (or ~~WIFE~~ of) Amelia Hogelgans

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Do.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hospital Baltimore, Md.

15 Filed ..... 19 ..... Registrar

SEP 13 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 10, 1921, that I last saw him alive on Sept 10, 1921, and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Psychosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. Gilchrist, M. D.

9/10/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Sept. 13 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 4033 E. Monument

THION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56903

CERTIFICATE OF DEATH.

79

D 56903

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 S. Wolfe ST.: W WARD)

2-FULL NAME Robert Mc Laughlin.

(a) RESIDENCE. NO. 321 S. Wolfe ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) City Engineer Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thos. Mc Laughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah J. Crouch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Richard Mc Laughlin
(Address) 321 S. Wolfe St.

15 Filed ..., 19 ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1921, to Sept 11, 1921.

that I last saw him alive on Sept 9, 1921.

and that death occurred, on the date stated above, at 11 45 p. m.

The CAUSE OF DEATH* was as follows:

Valvular Dis Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of May 1921

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. D. Mees, M. D.

, 19 (Address) 408 S Patterson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Sept. 14th 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	408 S Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56904

CERTIFICATE OF DEATH.

79 D 56904

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital St.: 73 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bacigalupo

(a) RESIDENCE. NO. 116 W. Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) 083

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Bartholome Bacigalupo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Katharine Bacigalupo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Katharine Bacigalupo. (Address)

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3 1921 to Sept. 12 1921

that I last saw him alive on Sept. 12 1921

and that death occurred, on the date stated above, at 1:25 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

OVER

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Sepsis.

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture.

(Signed) Frank E. Manning M. D.

19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Sept. 14 1921

20 UNDERTAKER Lilly & Geiler

ADDRESS 4033 Wolfe St.

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably came from bad tonsils.

D 56905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56905

CERTIFICATE OF DEATH. Maryland 172

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 900 Argyle Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Haney

(Residence in Baltimore: No. 900 Argyle Ave St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1851 (Year)

7-AGE. 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Fireman (Coal)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Gladden

(Address) 2415 N. Collington Ave

15- ASSISTED

Filed ..... (Date) 191 SEP 13 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (Instantaneous death)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fall out of window (accidental)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Sept. 12 1921 (Address) 280 S. Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Sept 13 1921

20-UNDERTAKER Paul Taylor — ADDRESS 916 Pennsylvania

CAUSE OF DEATH: In plain terms, important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56906 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 56906

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. St. Josephs Hospital St.: 1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Hitchens

(a) RESIDENCE. No. 427 So Madeira St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18. 1910.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph W. Hitchens.

11 BIRTHPLACE OF FATHER (city or town) Baltimore. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Wisniewska

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mary Hitchens. (Address) 427 So. Madeira St.

15 Filed SEP 13 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 12 1921.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1921. to Sept. 12, 1921.

that I last saw him alive on Sept. 12, 1921.

and that death occurred, on the date stated above, at 10:15 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empysema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 10, 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. P. Ponte, Jr, M. D.

. 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Sept 15 1921.
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Cam

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 56907 HEALTH DEPARTMENT—CITY OF BALTIMORE 09 D 56907

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Walton

(a) RESIDENCE. NO. 219 N. Poppleton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Esiah Walton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Anne Drien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant (Address)

15 Filed . 19 Registrar

Robert F. Harrison,

Burial Permit Clerk.

13 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-5 1921

17

I HEREBY CERTIFY, That I attended deceased from 8-17-21. to 9-5 . 1921.

that I last saw him alive on 9-4-'21 . 19 ,

and that death occurred, on the date stated above, at 12:45 A m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho - pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. S. Hollb. M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

UNIVERSITY OF MARYLAND

DATE OF BURIAL . 19 .

20 UNDERTAKER

Commissioner Health.

ADDRESS

Per. Wm. E. WOODALL

...TION is very important. See instructions on back of certificates.

Spec.—6-0-19—H. P. Co.—1000 Bks.

D 56908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56908

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital St., 10 WARD)

2-FULL NAME Delia Sullivan

(a) RESIDENCE. NO. 428 E. Biddle st. St., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Neppie Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Hospital Records M.T.H.

15 Filed SEP 13 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1921, to Sept. 6, 1921, that I last saw her alive on Sept. 6, 1921, and that death occurred, on the date stated above, at 10.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. Sputum, X-ray

(Signed) Francis L. Badaglacca M. D.

9-7-21. (Address) Municipal Tb Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 1921 SEP

20 UNDERTAKER: Commissioner Health.

ADDRESS

E. WOODALL

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56909 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56909

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Thomas

(a) RESIDENCE. No. N.E. cor. Lancaster & Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particulor kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): South Carolina

PARENTS

10 NAME OF FATHER Samuel Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER Rachel Hartin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): South Carolina

14 Informant (Address): Hospital Records M.T.H. UNIVERSITY OF MARYLAND.

15 Filed SEP 13 1921 Robert F. Harrison, Registrar Burial Permit clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1921, to Sept. 6, 1921, that I last saw him alive on Sept. 6, 1921, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in Sputum X-ray

(Signed) Francis L. Dalaghacca M. D.

9-6-21. 19 (Address) Municipal Tbc Hospa.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: SEP 1 1921 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates.
TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

(Collins) 15 | D 56910

D 56910

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~STILL BIRTH No.~~

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Southern Hospital

CITY OF BALTIMORE: (No. 2520 Greenmount Ave. ST.; 12 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Collins

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	

6-DATE OF BIRTH, September 11, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 2 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George Collins

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Miriam Buchingham

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miriam Collins

(Address) 1048 N. Fayette St.

15- Robert P. Harrison,
Filed ....., 191.....
Burial Permit Clerk.
Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191.....,
that I saw h..... alive on ..... 191.....,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion.

(Duration) ..... yrs. ..... mos. 2 hrs. ..... ds.

(Signed) Herbert E. Blake M. D.

....., 191... (Address) 1014 N. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ... 191...
20-UNDERTAKER Commissioner Health.	ADDRESS

JOHNS HOPKINS HOSPITAL
SEP 1921

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56911

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2822 Elliot ST.: 1st WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara May Elizabeth Meyers

(a) RESIDENCE. NO. 2822 Elliot ST., 1st WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June 21 '21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): infant

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Wm J. Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Eva May Cenna

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Brooklyn C. Md.

14 Informant: Wm J. Meyer

(Address): 2822 Elliot St.

15 Filed: Robert F. Harrison, Registrar

SEP 13 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1921, to Sept 12, 1921, that I last saw her alive on Sept. 10, 1921, and that death occurred, on the date stated above, at 9.40 A. m.

The CAUSE OF DEATH* was as follows:

Sub acute gastro enteritis

Wittle fed.

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary): Exhaustion (stomatitis)

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wm Wm Wright, M. D.

9/12. 1921 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER: Commissioner Health.	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56912 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 56912

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH City Hospital

CITY OF BALTIMORE: (No. 339 Bruce ST.: 19 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Holmes

(a) RESIDENCE. NO..... ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va,

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hosp. Records. (Address)

15 Filed Sep 13 1921, 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10-1921

17 I HEREBY CERTIFY, That I attended deceased from Sep. 7, 1921, to Sep 10, 1921 that I last saw him alive on Sep 10, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 339 Bruce St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. O'Neill M. D.

9-13 1921 (Address) City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

UNIVERSITY OF MARYLAND. 19

20 UNDERTAKER — ADDRESS

Commissioner Health.

SEP 13 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56913

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter White

(a) RESIDENCE. No. ~~University Hospital~~ 29 E. Lee St. St., 29 E Lee St Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Self.
(Address) UNIV

15 Filed 19 Robert T. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1921, to Sept 3, 1921

that I last saw him alive on Sept 2, 1921

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Pleurisy with effusion (left)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Miliary Tubercu-losis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Not as yet.

What test confirmed diagnosis? Exam of sputum.

(Signed) F. G. Haldew. M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

SEP 1 1921

Commissioner Health.

Rev. Wm. H. Woodall

1324

SEP 13 1921 Burial Permit Clerk.

MAKE STATEMENTS OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

150 521
D 56914

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56914

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 7 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Denmark

(a) RESIDENCE. No. Underwood Rd St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Denmark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eleanor Hooker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records.

15 Filed . 19 Robert F. Harrison Registrar

EH 13 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 - 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 6 - 1921, to Sept 7 - 1921, that I last saw h[illegible] alive on Sept 7 - 1921, and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity -

(duration) yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Hemorrhage from umbilicus
Infection of umbilicus -

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? home -

Did an operation precede death? no Date of

Was there an autopsy? yes -

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

Sept 7, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19
20 UNDERTAKER	ADDRESS
	1921

CAUSE OF DEATH in plain terms. DO NOT USE MEDICAL TERMS. INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. PHS Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Daniel.

(a) RESIDENCE No. US PHS Hosp. #56 Baltimore ST., 39 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	32 yrs.	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrook Registrar

(Address) US. PHS Hosp. #56 Balto. Md.

15 Filed SEP 13 1921 Robert P. Harrison. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1921, to Sept. 11 1921.

that I last saw him alive on Sept. 11 1921,

and that death occurred, on the date stated above, at 9'40 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far adv. active.

Feb. 2, 1921 (duration) --- yrs. --- mos --- ds.

CONTRIBUTORY (Secondary) --- (duration) --- mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Clinic report.

(Signed) Thomas R. Payne M. D.

, 19 (Address) Senior Surgeon (R) US PHS Hosp. #56. Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phoenix Va.

DATE OF BURIAL Sept 13 1921

20 UNDERTAKER S Ferguson

ADDRESS 1127 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 56916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56916

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. PHS Hosp. #56.
CITY OF BALTIMORE. (No. Fort McHenry Baltimore Md ST., 24 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bellitto

(a) RESIDENCE NO. US PHS Hosp. #56 Baltimore ST. Md. 40 WARD
(Usual place of abode)
(If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs J Bellitto

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	29 yrs.	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laberer
(b) General nature of industry, business, or establishment in which employed (or employer) ---
(c) Name of employer ---

9 BIRTHPLACE (city or town)
(State or country) Md. Talbot Co. Talbot Co. Md.

PARENTS

10 NAME OF FATHER --

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Edgar T Rosenbrock Registrar
(Address) US PHS Hosp. #56 Baltimore Md.

15 Filed Robert P. Harrison, , 19 Registrar
Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1921 to Sept. 13, 1921 that I last saw him alive on Sept. 13, 1921 and that death occurred, on the date stated above, at 6'45 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far adv. active.

Jan. 31, 21 (duration) -- yrs. -- mos. -- ds.

CONTRIBUTORY (Secondary) -- -- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam. Clinic report.

(Signed) Thomas R. Payne M. D.
Senior Surgeon (R)
, 19 (Address) USPHS Hosp. #56 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Normstown Pa	Sept 13 1921
20 UNDERTAKER J Lenox Brendle	ADDRESS Md

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56917

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56917

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2028 E. Hoffman St.: 8 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ottis Baker

(a) RESIDENCE. No. 2028 E. Hoffman St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 2yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17- 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Chester Baker

11 BIRTHPLACE OF FATHER (city or town) Louisville (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Sophia Pitt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Chester Baker
(Address) 2028 E Hoffman St

15 Filed Sept 13 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

P 13 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 8 1921 to Sept 12 1921 that I last saw him alive on Sept 12 1921 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Cook M. D.

9/13. 1921 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 13 1921

20 UNDERTAKER Jas E Keller

ADDRESS 233 N Jeffers St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56918

CERTIFICATE OF DEATH.

D 56918

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 4142 E Fayette ST.: 76 WARD)

2-FULL NAME Michael Bokene

(a) RESIDENCE. NO. 4142 E Fayette ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Theresa Bokene

6 DATE OF BIRTH (month, day, and year) Dec 5-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Augustine Bokene

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Dominica Bruno

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Theresa Bokene

(Address) 4142 E Fayette

15 Filed SEP 13 1921 19 Robert F. [illegible] Registrar

Burial Permit Clerk.

S. B.—WRITE PLAINLY. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. THIS INFORMATION should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1921

17 I HEREBY CERTIFY, That I attended deceased from August 5 1921, to Sept 13, 1921.

that I last saw him alive on September 11 1921.

and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Asthma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What tests confirmed diagnosis? —

(Signed) Maxwell L. Mayer M. D.

9/13/21 (Address) 3113 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem

DATE OF BURIAL Sept 16 1921

20 UNDERTAKER John Herring & Co

ADDRESS 220 N Calvert

D 56919 HEALTH DEPARTMENT—CITY OF BALTIMORE 184 D 56919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 154 N Lombard St

CITY OF BALTIMORE (No. Druppe Road NW ST. 26 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph D Moudra

(Residence in Baltimore: No. 4016 E Lombard St. St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE, 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Greece

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Greece

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mike Moudra

(Address) 4016 E Lombard

15-

Filed ....., 191.....

Registrar.

SEP 1 1927 Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 9, 1927 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Structural skull malformation
hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) By blunt instruments in hands of some person known or unknown (Duration) yrs. mos. ds.

(Signed) Henry Lyon Weaver M. D. (Coroner)

Sept 13, 1927 (Address) 1000 Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem

DATE OF BURIAL, Sept 14, 1927

20-UNDERTAKER J Kerns & Co

ADDRESS 2007 Aliceanna

(Corpsew)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56920

CERTIFICATE OF DEATH.

79 ✓ D 56920

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 1236 Arlington St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Denison Caipsew

(Residence in Baltimore: No. 1236 Arlington St, St.; yrs. 4) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE: 34 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Shoe Maker

9-BIRTHPLACE (State or Country): lives in Balt-4 years born in Norfolk Va

PARENTS.

10-NAME OF FATHER: Silas Copson

11-BIRTHPLACE OF FATHER (State or Country): Va

12-MAIDEN NAME OF MOTHER: Magdie Linton

13-BIRTHPLACE OF MOTHER (State or Country): Eaton Shore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R A Elliott

(Address) 1725 Ashland Ave.

15-

Filed ....., 191.....

COLLECT & ADJUSTED

SEP 14 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... Sept. 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

9-12, 1921, (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Sept. 14, 1921
20-UNDERTAKER Mrs. R A Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omit technical or obscure terms. Be sure that all items are important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56921 ✓ 170 D 56921

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital 14 REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ralph Goodman

(Residence in Baltimore: No. 1511 Mt Royal Ave St.; 50 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, Widower WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	

6-DATE OF BIRTH, Dec 20 (Month) (Day), 1844 (Year)

7-AGE,	If LESS than 1 day,
76 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tobacco Dlr
(b) General nature of Industry, business, or establishment in which employed (or employer) ..... retired

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Meyer Goodman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Pauline Newmark

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Leon Goodman

(Address) ..... Park Circle Apts

15- SEP 14 1921 ROBERT J KRAUTER

Filed ..... 191. ..... Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1921, to Sept 13 1921, that I saw h[illegible]alive on Sept 13 1921, and that death occurred, on the date stated above, at 8-25 PM.

The CAUSE OF DEATH* was as follows:

..... Chronic Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

913, 1921. (Address) ..... Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Hebrew	Sept 15, 1921
20-UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad ave

Martin

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56922

CERTIFICATE OF DEATH.

79 D 56922

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Argyle St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Martin

(Residence in Baltimore: No. 1208 Argyle Ave. S. 83 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, May 10 (Month), (Day), 1838 (Year)

7-AGE, 83 yrs. 4 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Agent
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm W Martin

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Gracie Parris

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna Martin

(Address) 1208 Argyle Ave

15-

Filed SEP 14 1921, 191.....

ROBERT P. KRAUTER

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 11 (Month), (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 12 1921, to Sept. 11 1921, that I saw him alive on Sept. 10 1921, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

I. Cerebral Embolism

(Duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Arthritis

(Duration) 1 yrs. 1 mos. 0 ds.

(Signed) W. T. Carr M. D.

Sept 14 21, 191... (Address) 515 Mt Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem. DATE OF BURIAL, Sept. 14, 1921

20-UNDERTAKER Samuel T Hemsley ADDRESS 578 N Biddle St

D 56923

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 56923

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 106 E. Hamburg St. St.: 24 104 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Baer.

(Residence in Baltimore: No. 106 E. Hamburg St. St.; 1 yrs., 4 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, April 15th. 1920., 1
(Month) (Day) (Year)

7-AGE, 1 yrs. 4 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John H. Baer.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER Emma S. Charlton.

13-BIRTHPLACE OF MOTHER (State or Country), A. A. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma S. Baer. (mother)

(Address) 106 E. Hamburg St.

15-

Filed ..... 191.....

SEP 14 1921 ROBERT P. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 12th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
inquiry found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto K. Finnard M. D.
(Coroner.)

Sep. 12. 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Schwartz's Cemetery	Sept 14, 1921
20-UNDERTAKER F. A. Krauser & Son	ADDRESS 703 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. All questions must be answered. Every item important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 56924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56924

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 S. Clinton ST., 16 WARD)

2-FULL NAME Rosemarie Smith

(a) RESIDENCE NO. 232 S. Clinton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 200

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER William E. Smith

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary B. Koch

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant William E. Smith
(Address) 232 S. Clinton St.

15 Filed SEP 14 1921 19 ROBERT I. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6 1921 to Sept 13 1921.

that I last saw h er alive on Sept 13 1921.

and that death occurred, on the date stated above, at 11 30 A.M. m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Eugene Geller, M. D.

9/13, 1921 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem.

DATE OF BURIAL Sept 14 1921

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Mad Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Schmalenbach D-56925

56425

D 56925

164 D 56925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4614 Eastern Ave ST., No WARD)

2-FULL NAME Joseph Schmalenbach

(a) RESIDENCE No. 4614 Eastern Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Schmalenbach

6 DATE OF BIRTH (month, day, and year) Nov. 16, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	9	26	

8 OCCUPATION OF DECEASED 018

(a) Trade, profession or particular kind of work Minister at

(b) General nature of industry, business, or establishment in which employed (or employer) Mission on

(c) Name of employer E 16th St.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Max Schmalenbach

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown

14 Informant Clara Schmalenbach (Address) 4614 Eastern Ave

15 Filed SEP 14 1921 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 10th, 1921, to Sept 12th, 1921, that I last saw him alive on Sept 12th, 1921, and that death occurred, on the date stated above, at 3.00 a. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) ✓

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Adam Jod M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Erie Pa.	Sept 14 1921
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Fleet St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Possibly a ptomaine poisoning due to some food kind unknown.

Dr Robert Asquith St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56926

CERTIFICATE OF DEATH.

79 D 56926

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 N. Eutaw ST., 6 WARD)

2-FULL NAME Ella V. Worsham

(a) RESIDENCE NO. 20 N. Eutaw ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Albert E. Worsham

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Parker

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Joseph H. Worsham
(Address) 20 N. Eutaw St

15 Filed ..... 19 ..... Registrar

SEP 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1921, to Sept 12, 1921,

that I last saw h[illegible] alive on Sept 12, 1921,

and that death occurred, on the date stated above, at 5-35 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Robert J. Green M. D.

9-13-1921 (Address) 120½ Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL Sept 16 1921

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Eut St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-56927 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56927 CERTIFICATE OF DEATH. 124 D 56927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. Wheeler Ave ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Starhawk

(a) RESIDENCE. No. 18 N. Wheeler Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John J Starhawk

6 DATE OF BIRTH (month, day, and year) Dec 20, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jeremiah Myerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) John H Starhawk 18 N Wheeler ave

15 Filed SEP 14 1921 . 19 ROBERT I. FEATHER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 12 19 21

17 I HEREBY CERTIFY, That I attended deceased from during, to past, 19 07, that I last saw h... alive on 4 years, 19 21, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? C

Did an operation precede death? C Date of C

Was there an autopsy? C

What test confirmed diagnosis? C

(Signed) Dr Theo. Kalmenson M.D.

Sept 13-21 (Address) 345 So Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 15 1921
20 UNDERTAKER	ADDRESS
W M Routson	Greene & Saratoga

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56928

D 56923

CERTIFICATE OF DEATH.

782-5692 A

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 W. Mount St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa. F. Penington

(a) RESIDENCE. No. 31 W. Mount St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Penington

6 DATE OF BIRTH (month, day, and year) Aug 13 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ludwig Edler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Gresia Rebel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Abraham Penington (Address) 31 W. Mount St

15 Filed SEP 14 1921 19 ROBERT A. LEACHTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921 to Sept 12 1921 that I last saw h.. alive on Sept 12 1921 and that death occurred, on the date stated above, at 10.05 m.

The CAUSE OF DEATH* was as follows:

acute cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Dawson M. D.

9/14 1921 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Sept 15 19 21

20 UNDERTAKER for Foerderer Son ADDRESS 2173 E. Pra

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact SPELLING of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56929

64

56929

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 501 Harford Rd ST. 27 WARD)

2-FULL NAME William E. Rayne

(a) RESIDENCE No. 501 Harford Rd. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred all Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Rayne

6 DATE OF BIRTH (month, day, and year) March 25 1865

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
56	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Same

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William A Rayne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret A Snow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Fannie Rayne

(Address) 501 Harford Rd.

15 Filed SEP 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 29 , 1921 , to Sept 11 , 1921 .

that I last saw him alive on Sept 11 , 1921 ,

and that death occurred, on the date stated above, at 11.40 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) Right Hemiplegia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

9/13. 1921 (Address) Hamilton Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pinewood Cemetery	9/14 '21
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. ATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks. Maria Roehrer

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 56930

B 56930

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. St.: 1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Roehrer

(a) RESIDENCE. No. 110 Duncan Alley Ward. St. Anns #20

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Preller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. John Preller

(Address) 1635 Augusta Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1921, to Sept. 14, 1921, that I last saw her alive on Sept. 13, 1921, and that death occurred, on the date stated above, at 5.10 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

, 19 (Address) St Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept. 17 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

CAUSE OF DEATH in plain terms, so that a ... TION is very important. See instructions on back of certificates.

COPY OF RECORD

Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

56931 HEALTH DEPARTMENT—CITY OF BALTIMORE 56931

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr Nathan Sugar.

(Residence in Baltimore: No. 2315 W. North Ave. St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, [illegible], 1[illegible] (Month) (Day) (Year)

7-AGE, 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hat Maker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, [illegible]kam

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER [illegible]kam

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Baltimore

15- [illegible] BURIED SEP 1 1921

Filed [illegible] 191[illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 9th (Month) 11th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/5 1921, to 9/11 1921, that I saw h[illegible] alive on 9/11th 1921, and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Post operative Gastroenterostomy

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

9-14-21 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 9 ds. In the State 30 yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 2315 W North Ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew Int Carmel — DATE OF BURIAL, [illegible], 1921

20-UNDERTAKER Jack Lewis — ADDRESS [illegible]

Important. See instructions on back of certificate.

Spec.—6-4-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D/56932

64r

CERTIFICATE OF DEATH.

56932

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO 1210 N [redacted] Ave WARD)

2-FULL NAME Margaret Lentz

(a) RESIDENCE. NO 1210 N Luzerne Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Widow of Chas Lentz

6 DATE OF BIRTH (month, day, and year): Nov 10/1862

7 AGE — Years: 58 — Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): France

PARENTS

10 NAME OF FATHER: Frank Glasse

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER: Mary Berk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant: Mrs Emma R Kohlhafer (Address) 1210 N Luzerne Ave

15 Filed ....., 19..... Registrar

ROBERT J. KRAUTER

Burial Permit Clerk

CAUSE OF DEATH in plain terms, no abbreviations or symptoms. Read carefully back of certificates. INFORMATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 13 1924

17 I HEREBY CERTIFY, That I attended deceased from 9.11, 1924, to 9.13, 1924, that I last saw h[redacted] alive on 9.13 1924, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows: over

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Paralysis.

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Purnell Tyson, M. D.

9.13 1924 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemt — DATE OF BURIAL: Sept 16 1924

20 UNDERTAKER: H M Cook 502 E North Ave — ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "L[illegible]Foreman," "Manager," "Dealer," etc., wit[illegible] precise specification, as *Day laborer, Farm[illegible] Laborer—Coal mine, etc.* Women at home, w[illegible] engaged in the duties of the household only, [illegible] *Housekeepers* who receive a definite salary, [illegible] be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec.—6-9-19—H. P. Co.—1000 Bks.

2007 Boome

D 56933

HEALTH [redacted] OF BALTIMORE

D 56933

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2007 ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Margaret Klemm

(a) RESIDENCE. NO. 2007 Boome ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles H. Klemm

6 DATE OF BIRTH (month, day, and year) April 6 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Francis L. Klemm

(Address) 221 N. Calvert St

15 Filed Sept 15 1921 Robert J. Harrison, Registrar

P 14192

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to Sept 12, 1921, that I last saw h[illegible] alive on Sept 12 1921, and that death occurred, on the date stated above, at 7 AM.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Benj. Koadow, M. D.

9-13-1921 (Address) 2306 Eutaw Pl,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County

DATE OF BURIAL: Sept 15 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fill in all items of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56934

CATE OF DEATH.

790 56934

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH [redacted]

CITY OF BALTIMORE: (No. 2406 N. Lanvale ST., 16 WARD)

2-FULL NAME Morgan Walker

(a) RESIDENCE NO. 2406 N. Lanvale ST., WARD

(Usual place of abode) (If noo-resideot give city or towo and State)

Length of residence in city or lown where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary E Walker

6 DATE OF BIRTH (month, day, and year) on Rec

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
[redacted]	72	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Bennett Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rebecca Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or eouotry) Balto Md

14 Informant Mrs Mary Walker (Address) 2406 Lanvale St

15 Filed Sept 13 19 21 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, aod year) Sept 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Sept 12, 1921, that I last saw h alive on Sept 12, 1921 and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Senile debility

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wm Lee Lamman M. D.

(Address) 831 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 15 1921
20 UNDERTAKER William Cook	ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

14 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56935

CERTIFICATE OF DEATH.

64 D 56935

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 N Caroline ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Heaphy.

(a) RESIDENCE. NO. 1624 N Caroline ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62.		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Heaphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Loughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J Hennessy

(Address) 1624 N. Caroline

15 Filed SEP 14 1921 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 11 1921 to Sept 12 1921 that I last saw h.. alive on Sept 12 1921 and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis (probably) (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Evidence

(Signed) William R. Heaphy M. D.

9/14, 1921 (Address) 203 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Sept 15 1921
20 UNDERTAKER	ADDRESS
E. J Fanning & Son	1625 E Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56936

HEALTH DEPARTMENT—CITY OF BALTIMORE

56936

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 Clarendon St. 23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella Trupper

(a) RESIDENCE. No. 1713 Clarendon St., 23 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				1 hr.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph A Trupper

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Brogan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penna

14 Informant Joseph A. Trupper
(Address) 1713 Clarendon

15 Filed 19

Registrar

Burial permit issued SEP

CAUSE OF DEATH in plain terms, so that it may be understood. Name of disease alone insufficient. Indefinite terms, such as "Debility," "Old Age," "Exhaustion," "Heart Failure," etc., should be explained by the cause producing them. Fill in all blanks. Use ditto marks only when they will not be misunderstood. Write plainly with pen and ink. Do not abbreviate. Consult your family physician before filling out this certificate. Your assistance is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 14, 1921, to Sept 14, 1921,

that I last saw h alive on Sept 14, 1921,

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Bifid Spine
(Congenital)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Campbell, M. D.

Sept 14 1921 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A&C Co	9-14 1921
20 UNDERTAKER	ADDRESS
E & B Stark	115 E Lexington

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56937

CERTIFICATE OF DEATH.

130 D 56937

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Adelaide Newman

(Residence in Baltimore: No. 904 N. Eutaw Ave St.; 32 yrs., 11 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, October 9th, 1888
(Month) (Day) (Year)

7-AGE, 32 yrs. 11 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edgar Bremer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Rebecca Campbell

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amos C. Newman

(Address) 904 N. Eutaw Ave.

15-

Filed....., 191.....
Registrar.

Robert P. Harrison,

SEP 14 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep 9 1921, to Sep 12 1921, that I saw her alive on Sep 12 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis -

..... (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Pelvic Inflammatory Disease

..... (Duration) 1 yrs. mos. ds.

(Signed) Edwards S. Levy, M. D.

1-2-1-2..., 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 3 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, Sept. 15th, 1921.

20-UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 56938

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 S. Clinton ST.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Witte

(a) RESIDENCE. NO. 2109 S. Clinton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(~~or WIFE~~) Augusta Witte

6 DATE OF BIRTH (month, day, and year) Oct. 3-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Geo. H. Mack
(Address) 2109 S. Clinton St.

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Sept 13, 1921, that I last saw h... alive on Sept 13, 1921, and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Gangrene of foot

(duration) 1 yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) M. J. McAvoy M. D.

Sept 14 1921 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Sept 15 1921
20 UNDERTAKER	ADDRESS 1739 Eager
Pinkler & Pinkler	

CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of ... k of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56939

CERTIFICATE OF DEATH.

80 D 56939

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2534 Edmondson Ave ST., 16 WARD)

2-FULL NAME Emma K Welty

(a) RESIDENCE NO. 2534 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theo F. Welty

6 DATE OF BIRTH (month, day, and year) Oct. 8 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	63	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann Welty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ray Welty (Address) 2534 Edmondson Ave

15 Filed ..... 19 SEP 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1921 to Sept. 13 1921, that I last saw her alive on Sept. 13 1921, and that death occurred, on the date stated above, at 1.12 m.

The CAUSE OF DEATH* was as follows: Angina Pectoris

Attacks for (duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis (duration one yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.

Was there an autopsy? no

What test confirmed diagnosis? Acute pain MC

(Signed) Chas. H. Phillips M. D.

. 19 (Address) 2900 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boonsboro Md.

DATE OF BURIAL Sept 14 1921

20 UNDERTAKER Wm J Pickington

ADDRESS Rockville

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF BURIAL and ADDRESS are very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

150461
D 56940

CERTIFICATE OF DEATH.

104 D 56940

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Kosfka

(a) RESIDENCE NO. 718 S Decker Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): Off

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frank Kaska

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Mary Luis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Johns Hopkins Hospital (Address) Decker

15 Filed . 19 Registrar

Robert F. Harrison,

SEP 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2nd, 19..., to Sept. 13, 1921, that I last saw her alive on Sept. 13, 1921, and that death occurred, on the date stated above, at 4 35 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Horace G. Stewart, M. D.

9/13, 1921 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Sept 14 1921.
20 UNDERTAKER: Wendell Appel & Son	ADDRESS 37 S Howard

mation should be carefully supplied, so that it may be properly classified. Entire satisfactory answers to each item are required. CAUSE OF DEATH in plain terms, so that it may be properly classified. Entire satisfactory answers to each item are required. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56941

CERTIFICATE OF DEATH.

X 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Tuberculosis Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Skalauskas

(a) RESIDENCE. NO. Liberty Hotel. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Miner 086

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): West Virginia (?)

PARENTS

10 NAME OF FATHER Phillis Skalauskas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Ann Baneas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Hospital Records M.T.H.

15 Filed SEP 14 1921, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1921, to Sept. 11, 1921, that I last saw him alive on Sept. 11, 1921, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary emphysema PTH

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Catarrhal infection of bronchial tree (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Aubrey, M. D.

9-12-21, 19.. Address Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Thomas W. V. a	Sept 14 1921
20 UNDERTAKER	ADDRESS
Mrs - Mrs N S' Brick	1834 W. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

SEP 14 1921

Robert F. Hartman, Registrar of Vital Statistics

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy." "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Possibly tuberculous in origin

D 56942 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 56942

CERTIFICATE OF DEATH.

78

REGISTERED NO. C

1 PLACE OF DEATH
CITY OF BALTIMORE (No. Maryland Penitentiary St. 10 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Slen Smart
(Residence in Baltimore: No. — Md. Penitentiary St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	col	Sgl

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 ..... (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Jos. Smart

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country). ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Beal
(Address) .....

15-
Filed ....., 191.... Registrar.
Robert P. Harrison,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Sept (Day) 10, 1914 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage
following ..... Epilepsy
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
Sept 11, 1914. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Sept 14, 1914
20-UNDERTAKER	ADDRESS
Mr & Mrs W. S. Frost	Md Penit

Sept 14 1921 Burial Permit

S. B.—Every item of information should be carefully supplied. Properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Wire Ball after, dimmer returned to Cell & disposed.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage*,	*Meningitis*,	*Phlebitis*,
Cellulitis,	*Gangrene*,	*Miscarriage*,	*Pyæmia*,
Childbirth,	*Gastritis*,	*Necrosis*,	*Septicæmia*,
Convulsions,	*Erysipelas*,	*Peritonitis*,	*Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D. 56943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 56943

78-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N. 26th ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benita Estella Botterell

(a) RESIDENCE NO. 413 N. 26th ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX [redacted]

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Botterell

6 DATE OF BIRTH (month, day, and year) Sept 25th 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER James A Gordon

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Thompson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Mrs Ella Gordon

(Address) 3630 Wasena ave

15 Filed SEP 14 1921, 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1921, to Sept 13, 1921.

that I last saw her alive on Sept 13, 1921

and that death occurred, on the date stated above, at 3:20 P.M. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(See remarks)

(duration) ..... yrs. mos 16 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Physical signs

(Signed) R B Hammond — M. D.

, 19 (Address) 3347 Charlotte, Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's County Hanger	Sept 16th 1921
20 UNDERTAKER	ADDRESS
Williams H. Higdon	3624 Ash St

mation should be carefully supplied. Exact spelling of names may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56944

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 56944

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Belt ST.: 24th WARD)

2-FULL NAME John W. Eaton

(a) RESIDENCE. No. 1527 Belt ST., 24th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth V. Eaton

6 DATE OF BIRTH (month, day, and year) April 2, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	11	

073

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R. R. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) (Retired).

(c) Name of employer B & O. R. R.

9 BIRTHPLACE (city or town) (State or country) New Freedom, Pa. Pennsylvania

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Wife - Mrs. John W. Eaton (Address) 1527 Belt St.

15 Filed Sept 14 1921, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is necessary TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from August 9, 1921, to Sept 13, 1921, that I last saw him alive on Sept 12, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashbury Cem. Restoration	9/16 1921
20 UNDERTAKER	ADDRESS
I. Few McCully	130 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56945 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 56945

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1442 Reynolds ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Jenjenski

(a) RESIDENCE. NO. 1442 Reynolds ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/27/21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 008

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Valtini Jenjenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Bethmier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Balto

14 Informant Mrs. Josephine Bethmier
(Address) 1442 Reynolds St

15 Filed ..... 19 Robert F. Harrison, Registrar
Burial Permit Clerk

P 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/13/21

17 I HEREBY CERTIFY, That I attended deceased from Sept 3rd 1921, to Sept 13th 1921.

that I last saw him alive on Sept 13th 1921.

and that death occurred, on the date stated above, at 12 [illegible] p m.

The CAUSE OF DEATH* was as follows:

Pneumonia over

Pneumonia (duration) 1 mo yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Henry B Koll M. D.

19 (Address) 1203 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Brooklin	9/15 1921

20 UNDERTAKER ADDRESS

Elmer W. Conklin 924 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1203

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Enteritis.

Spec.—8-24-14—M. & T.—2000 Blks.

D 56946

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56946

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hosp. REGISTERED NO. C 40

CITY OF BALTIMORE: (No. 2000 W Pratt ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. John J. Strohmer.

(Residence in Baltimore: No. 2000 W Pratt St.; Age yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 15 (Day), 1866 (Year)

7-AGE, 55 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocerman Prop - 034
(b) General nature of industry, business, or establishment in which employed (or employer): 2000 W. Pratt St.

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George Strohmer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Catherine Strohmer

(Address) 2000 W. Pratt St.

15-

Filed....., 191.....

Registrar.

SEP 14 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July - 12 1921, to Sept. - 14 1921, that I saw h im alive on Sept - 14 - 1921; and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Fatal Lesion)

(Duration) about - 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Lloyd Johnson M. D.

....., 191... (Address) Bon Secours Hospital

Resident.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, 9/17, 1921

20-UNDERTAKER Elmer W. Conklin — ADDRESS 924 E Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Race distinction important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56947

40

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Hillmen ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Vandaniker

(a) RESIDENCE. NO. 1001 Hillman ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Vandaniker

6 DATE OF BIRTH (month, day, and year) Aug 13/1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Fritzpatrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Jacob Vandaniker 1001 Hillmen St

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 12 1921; to Sept 14 1921.

that I last saw alive on Sept 13 1921.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1001 Hillmen St

Did an operation precede death? No Date of

there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James McKinlow, M. D.

(Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	9/16 1921

20 UNDERTAKER Elmer W Conklin ADDRESS 424 E Eager

Sept 16 1921

mation should be given in these terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain

D 56948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56948

CERTIFICATE OF DEATH.

64

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. South Baltimore General Hospital ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter E. Craig.

(Residence in Baltimore: No. 1223 Scott St. 60 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, Do not know. (Month), (Day), 1 (Year)

7-AGE,	If LESS than 1 day,
60 yrs. ---------- mos. ---------- da.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar maker.
(b) General nature of industry, business, or establishment in which employed (or employer): 01

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Thomas Craig.

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER Mary. ----------

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John B. Adams. (nephew)

(Address) 1318 James St.

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 12th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. M. Emmart M. D.
(Coroner.)

Sep. 13., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....da. In the State .....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	Sept 16., 19 21
20-UNDERTAKER	ADDRESS
Geo Lemmlacker	647 W Pratt

N.B.—Every item of information should be carefully supplied. AGE in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 56949 HEALTH DEPARTMENT—CITY OF BALTIMORE. D 56949

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Elevator B Locust Point. ST. 19 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas L. Lafferty.

(Residence in Baltimore: No. 8 S. Calhoun St. St.; 65 yrs., 0 mos., 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, September 12th, 1866, (Month) (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
65 yrs. 0 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sheet Iron
(b) General nature of industry, business, or establishment in which employed (or employer): worker.

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William T. Lafferty.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie T. Lafferty. (wife)

(Address) 8 S. Calhoun St.

15-

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 13th, 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Thos. M. Emmart M. D. (Coroner.)

Sep 14, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	9/16/21 19....
20-UNDERTAKER Wm. Cook	ADDRESS 1028 North

N. B.—Every item of information called for should be carefully considered, and the answer written in a plain hand. Special attention is called to the importance of correctly classified. Exact statement of OCCUPATION is very important, so that it may be properly classified. See instructions on back of certificate.

Robert E. Harrison
Sep 14 1921
Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Peter Garnett

D 56950 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56950

103

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1124 Chuncii ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Garnett

(a) RESIDENCE. NO. 1124 Chuncii ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Garnett

6 DATE OF BIRTH (month, day, and year) unknown 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Essex co (State or country) Va

PARENTS

10 NAME OF FATHER Cesar Garnett

11 BIRTHPLACE OF FATHER (city or town) Essex co (State or country) Va

12 MAIDEN NAME OF MOTHER Kitty Haines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Celia Whiting

(Address) Brandles Ct Hughes St

15 Filed SEP 15 1921 19.. BOARD OF HEALTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1921, to Sept 12, 1921, that I last saw h[illegible] alive on Sept 12, 1921, and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) A W Hinson, M. D.

. 19 (Address) 712 S Ann St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U.S. National Ct

DATE OF BURIAL Sept 15 1921

20 UNDERTAKER N. L. Brandel Son

ADDRESS 108 W Monty

National Ct

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56951

CERTIFICATE OF DEATH.

X78 D 56951

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) No. 2304 Penna Ave ST.: 15 WARD)

2-FULL NAME Esther Bernard.

(a) RESIDENCE. NO. 2304 Penna ave ST.: WARD Washington DC.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 ~~Single, Married, Widowed, or Divorced~~ (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Deceased 1840

6 DATE OF BIRTH (month, day, and year): May 29 1840

7 AGE: Years 81 | Months 3 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ~~[illegible]~~ 00

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Morris Bernard
(Address) 2304 Penna Ave

15 Filed . 19 ROBERT J. BRAUNE Registrar
By [illegible] Clerk

SEP 15 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 14 1921 to Sept 14 1921.

that I last saw her alive on Sept 14 1921.

and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) O. O. Lloyd, M. D.

. 19 (Address) 2232 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D. C.

DATE OF BURIAL: 9-16 1921

20 UNDERTAKER: David Sandheim

ADDRESS: 115 N. McKeyett

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or symptoms. See back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

VD 56952

150

D 56952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital St.: 7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby saunders

(a) RESIDENCE. No. 406 N. Eden St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 9 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Not Employed~~ 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Clarence Saunders

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Myra Stanley.

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant F.H. Cathrall (Address) Johns Hopkins Hospital.

15 Filed SEP 15 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1921 to Sept. 12, 1921 that I last saw her alive on Sept. 12, 1921, and that death occurred, on the date stated above, at 7:30 P.m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart. (Congenital)

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes (State Board Anatomy)

What test confirmed diagnosis? —

(Signed) F.H. Cathrall, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

SEP 16 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

(Thomas Quarles)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56953

CERTIFICATE OF DEATH.

15 - 18 v

D 56953

1 PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St. 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Thomas Quarrels

(Residence in Baltimore: No. 1374 N. Strieker St. St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, June (Month) 4 (Day), 1879 (Year)

7-AGE, 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Captain of Schooner
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Henry Quarrels

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna May Quarles

(Address) 1374 N. Strieker St

15- ROBERT S. [illegible]

Filed SEP 1 1927, 191... Burial Permit [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 16 (Day), 1912 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy ~~or inquiry~~.) thereon and from the evidence obtained by said (Inquest, autopsy or ~~inquiry~~.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Bullet wound in chest. Shot by some one at this time unknown. (Duration) Less than 1 hrs. ds.

CONTRIBUTORY (Secondary) as above. (Duration) a few yrs. mos. ds.

(Signed) W. K. Gronmal, M. D. (Coroner)

9-15, 1924 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, Sept. 15, 1924

20-UNDERTAKER James H. Dennis

ADDRESS 303 Cresotina St.

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Handwerger

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56954

CERTIFICATE OF DEATH.

79V

D 56954

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Morris Handwerger

(Residence in Baltimore: No. 124 N. Collington Ave St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, September (Month) 15, (Day) 1921. (Year)

7-AGE, 52 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...00...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham Solomon

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Marian Handwerger

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. Handwerger

(Address) 124 N Collington ave

15. Filed SEP 15 1921, 191.... ROBERT J KRAUTER Registrar.

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 15, (Day) 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 28, 1921, to September 15, 1921, that I saw h[im] alive on September 15, 1921, and that death occurred, on the date stated above, at 12.45 a m.

The CAUSE OF DEATH* was as follows:

(1) Myocardial Insufficiency (2) Auricular fibrillation

(3) Chronic Passive Congestion of Lungs and Liver

(4) Arteriosclerosis

..... (Duration) ..8.. yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Fidler Landsman M. D.

9/15, 1921. (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State 25 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 124 N Collington ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, Sept 17, 1921

20-UNDERTAKER M A Gleason — ADDRESS 1127 E Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56955

CERTIFICATE OF DEATH.

79 D 56955

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 N. Carrollton Ave ST.; 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Lewis

(Residence in Baltimore: No. 326 N. Carrollton Ave St.; 35 yrs. — mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Oct (Month) 26 (Day), 1834 (Year)

7-AGE. 86 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Dorchester Co. Md

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred R. Lewis

(Address) 1120 N. Fulton Ave.

15- SEP 15 1921 Filed....., 191.... ROBERT I. BRAUTIGAM Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 14, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1919, to Sept 14 1921, that I saw her alive on Sept 12" 1921, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) About 6 yrs. ....mos. ....ds.

(Signed) O. H. Dewald M. D.

Sept 14, 1921 (Address) 1817 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cambridge Md	Sept. 15, 1921.
20-UNDERTAKER John F. Denny	ADDRESS 715 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56956

CERTIFICATE OF DEATH.

64D 56956

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 3906 Forest Park Ave ST.: (15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Chas Heuselmeyer

(a) RESIDENCE. No 3906 Forestpark Ave ST., 15 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 14 Sept 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired sea Captain

(b) General nature of industry, business, or establishment in which employed (or employer) Government

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indea

PARENTS

10 NAME OF FATHER Chas Heuselmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cora Von Gemmingen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Counselor Heuselmeyer
(Address) 3906 Forestpark ave

15 Filed SEP 13 1921 ROBERT I. GRIFFITH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1921, to Sept 13, 1921.

that I last saw him alive on Sept 13, 1921.

and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
Hemiplegia.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo W Wentz, M. D.

10/14. 1921 (Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 16 1921
20 UNDERTAKER	ADDRESS
Josiah Sypes	1600 N North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56957

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56957

CERTIFICATE OF DEATH.

105

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

2-FULL NAME Julia Burns

(a) RESIDENCE. No. Mt Hope Retreat ST. 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Doubtful ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Mr Burns

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	63	8/25—1858		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Ireland

PARENTS

10 NAME OF FATHER Luke Donahue

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Ryan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md.

15 Filed SEP 15 1921 19 ROBERT I. GRAFTON Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 12th 1918 to Sept 14 1921

that I last saw her alive on Sept 14 1921

and that death occurred, on the date stated above, at 12. noon m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

abt (duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) Dementia Senile

abt (duration) 3 yrs 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis J Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: Sept 16th 1921

20 UNDERTAKER: J. J. Cavanaugh & Son — ADDRESS: 901 Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 56958

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 56958

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 Eastern Ave ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul William Brichetto.

(a) RESIDENCE. NO. 819 Eastern Ave St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William Brichetto.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Leonora Genes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs William Brichetto.
(Address) 819 Eastern Ave

15 Filed . 19 SEP 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1921, to Sept 14, 1921, that I last saw h— alive on Sept 14, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis Colitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Wentworth, M. D.

(Address) 712 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Sept 16th 1921
20 UNDERTAKER	ADDRESS
John J Cowan & Son	901 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 56959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56959

104

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 S Bond ST., 3 WARD)

2-FULL NAME Alexsander Wysocki

(a) RESIDENCE NO. 621 S Bond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .....min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— 000

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Frank Wysocki

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Mary Andrychawski

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mary Wysocky (Address) 621 S Bond

15 Filed ..... 19 SEP 15 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1921, to Sept. 14, 1921, that I last saw him alive on Sept 14, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Waterville Balto Co. Md.

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? —

(Signed) John H. Rehberger M. D.

19 (Address) 1709 Aliceanna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Sep 15 1921

20 UNDERTAKER John A Weber — ADDRESS 1803 Park Ave

Mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56960 ✓ D 56960

CERTIFICATE OF DEATH.

150

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 E. 27th ST. 12 WARD)

2-FULL NAME Alleine Susemihl

(a) RESIDENCE. No. 321 E. 27th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 '21

7 AGE	Years	Months	Days	If LESS than 1 day 22 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John L. Susemihl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City Germany

12 MAIDEN NAME OF MOTHER Jerdaldine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant John L. Susemihl
(Address) 321 E. 27th

15 Filed SEP 15 1921 19 ROBERT J. KRAUTER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Sep 15, 1921, to Sep 15, 1921, that I last saw h[illegible] alive on Sep 15, 1921, and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Patient to closure of valve between atrium

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? progressive

(Signed) Cyanosis J. H. Duke M. D.

1921 (Address) 928 E North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem DATE OF BURIAL Sept 16 1921

20 UNDERTAKER Philip Henry ADDRESS 2016 Aisquith

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 56961

REGISTERED NO.....

D 56961

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4235 Euclid Ave. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Archer Eyerly

(a) RESIDENCE. NO. 4235 Euclid Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William S. Eyerly

6 DATE OF BIRTH (month, day, and year) Sept. 21" 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Port Deposit, Harford Maryland

PARENTS

10 NAME OF FATHER William Cather

11 BIRTHPLACE OF FATHER (city or town) (State or country) Port Deposit Maryland

12 MAIDEN NAME OF MOTHER Rachel E. Plummer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South River Md.

14 Informant Margaret C. Cooney (Address) 4235 Euclid Ave.

15 Filed SEP 15 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15" 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 25 1921, to Sept 15 1921, that I last saw h.. alive on Sept 15 1921, and that death occurred, on the date stated above, at 5 A. m.

THE CAUSE OF DEATH* was as follows: Acute Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. W. Jones, M. D.

9-15-21 (Address) Darlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 17" 1921

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 56962 | 1921 D 56962

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 Patapsco Ave ST.) Brooklyn (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Munn

(a) RESIDENCE. NO. 533 Patapsco Ave ST. Brooklyn WARD. 25

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a ~~If married, widowed, or divorced~~ HUSBAND of (or WIFE of) Annie Munn

6 DATE OF BIRTH (month, day, and year) Jan. 12 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	8	1	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Car Works.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo. F Munn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Munn (Address) Brooklyn

15 Filed SEP 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1921, to Sept 13, 1921.

that I last saw h— alive on Sept 11, 1921.

and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) H Lawson

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. F Brooke M. D.

, 1921 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a a Co	9-16 1921

20 UNDERTAKER E r B Hale ADDRESS 115 Elliott St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—R. P. Co.—1000 Bks.

D 56963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 36963

63-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 891 N. Lombard ST.: 18 WARD)

2-FULL NAME Francis B. Seaman.

(a) RESIDENCE. NO. 891 N. Lombard ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 30 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Francis B Seaman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Lizzette Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Francis B Seaman
(Address) 891 N Lombard st

15 Filed 9/15/21 SEP 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1921, to Sept 14, 1921, that I last saw him alive on Sept 14, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:
Cardiac failure myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia.

(duration) yrs. mos. ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Edw. F. Cronkheim, M. D.

9/15/21 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine	Sept 17 1921
20 UNDERTAKER John J Fields	ADDRESS 1200 W Fayette

CAUSE OF DEATH in plain (terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56964

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56964

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 S Pulaski St. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Felix Batza

(a) RESIDENCE NO. 310 S Pulaski ST. 20 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 mon yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 500

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Louis Batza

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Celia Clemens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Louis Batza (Address) 310 S. Pulaski St.

15 Filed SEP 15 1927, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1927, to Sept 14, 1927.

that I last saw h alive on Sept 14, 1927.

and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Acetonuria Coma 1 hour

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Stewart Ka, M. D.

Sept 15, 1927 (Address) 2227 N Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 16 1927
20 UNDERTAKER	ADDRESS
George L. Schwartz Bro	2101 Madison Ave

mation should be carefully supplied. Age should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1643
56965

CERTIFICATE OF DEATH. X 45

56965

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (ST.) 7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Hobbs

(a) RESIDENCE NO. Athens (ST.) Alabama (WARD) Athens Ala.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1/ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30 - 1858

7 AGE: 62 Years | 9 Months | 16 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Alabama

PARENTS

10 NAME OF FATHER: Thos H. Hobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Anna J. Benagh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Johns Hopkins Hospital Record

15 Filed ... 19 ... Registrar

ROBERT J. KRAUSE

SEP 15 1921 Board of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 19 - 1921. to Sept 16 - 1921.

that I last saw h... alive on Sept 16 - 1921.

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma of right Kidney

(duration) 2 yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Metastasis to Liver

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Athens, Ala

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Eugene L. Shaw, M. D.

Sept 15, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Athens Alabama — DATE OF BURIAL: Sept 16th 1921

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56966

CERTIFICATE OF DEATH.

43 D 56966

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1309 John ST.: 11 WARD)

2-FULL NAME Margaret Slemmer Corson

(a) RESIDENCE. NO. 1309 John ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed, or Divorced~~ (write the word): Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of: Charles Fallen Corson

6 DATE OF BIRTH (month, day, and year): 2-18-1856

7 AGE: Years 65 Months 6 Days 26 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer): at Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Georgetown D.C.

PARENTS

10 NAME OF FATHER: Charles Slemmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Montgomery Co Pa.

12 MAIDEN NAME OF MOTHER: Mary A Willson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rockville Md.

14 Informant: Alice W Corson
(Address): 1309 John St.

15 Filed SEP 15 1921 19.. Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 18 1918, to Sept 14 1921, that I last saw h.. alive on Sept 5 1921, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma (mammas)

(duration) 3 yrs. - mos. ds.

CONTRIBUTORY (Secondary) Cerebrospinal metastasis; Pulm. oedema (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 1918

Was there an autopsy? No

What test confirmed diagnosis? Clinical diag., pathological diag. of specimen at time of operation

(Signed) Louis L. Hamburger M. D.

19 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norristown Pa.

DATE OF BURIAL: 2-16 1921

20 UNDERTAKER: Stuart Jenkins Sons Co

ADDRESS: McCullough Orchard

mation should be carefully supplied. All should be filled. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

150 531
D 56967

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56967

CERTIFICATE OF DEATH.

60

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 25 WARD)

2-FULL NAME John Lenert

(a) RESIDENCE NO. 5 Elm St. Curtis Bay City. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of (or) WIFE of~~ John Lenert Sr. (father) same address

6 DATE OF BIRTH (month, day, and year) Nov 13 - 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Lenert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) John Hopkins Hospital Records

15 Filed . 19 Robert T. Morrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 7- , 1921 , to Sept. 14 , 1921 ,
that I last saw h alive on Sept. 14 , 1921 ,
and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Abscess of scalp
? Brain abscess
? Streptococcus septicemia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Sept 13, 1921

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Emile Holman , M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL Sept 16 1921

20 UNDERTAKER Frank Creech & Son

ADDRESS 1916 Eutaw Pl

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be pr
TION is very important. See Instructions on back of ce

OCCUPA-
of certificates.

15 1921

Spec.—1-10-21—M&T—1500 Bks.

D 56968

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56968

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1808 - Whole ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Sidney

(a) RESIDENCE NO. 1808 - Whole ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 31 - 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	10	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Howard Sidney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary Sidney

(Address) Same

15 Filed SEP 15 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1921, to Sept 14, 1921, that I last saw him alive on Sept 14, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 ? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) Walter D. Lackey M. D.

, 19 (Address) 1618-W-Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Sept 17 1921

20 UNDERTAKER Edw. Ruggold

ADDRESS 1462 Carey St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56969 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56969

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1547 Leslie ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Hardin

(a) RESIDENCE. NO. 1547 Leslie ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frank Hardin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince Georges Co. Md.

14 Informant Frank Hardin Sr.
(Address) 1547 Leslie St.

15 Filed Robert P. Harrison, Registrar

SEP 15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1921 to Sept. 11, 1921 that I last saw h[illegible] alive on Sept. 11, 1921 and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? [illegible]

What test confirmed diagnosis?

(Signed) John D. Quinn M. D.

9/13 1921 (Address) 1507 N. Dulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL Sept 16 1921

20 UNDERTAKER Edw. Lang gold ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 56970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56970

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 North Bradford ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Chauca

(a) RESIDENCE. NO. 10 North Bradford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	✓

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept 13, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. ... min.
✓	✓	✓	✓	30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ (00)

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md. 10 N. Bradford St.

PARENTS

10 NAME OF FATHER Charles Chauca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Garey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant H. H. Cathrall M.D. (Address) Johns Hopkins Hospital

15 Filed SEP 15 1921, 19 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from 7.30 AM Sept 13, 1921 to 9.00 AM Sept 13 1921 that I last saw him alive on Sept 13 1921, and that death occurred, on the date stated above, at 9.00 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

✓ (duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) ✓ (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? Yes (State Anatomical Board Case)

What test confirmed diagnosis? ✓

(Signed) H. H. Cathrall, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS 1921

Commissioner Health.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 56971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56971

CERTIFICATE OF DEATH.

K 129-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Minnie Ward

(a) RESIDENCE NO. Crisfield Md ST., WARD Crisfield Md
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wright Ward

6 DATE OF BIRTH (month, day, and year) Feb 22-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Laird

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. H. L. Saumenig. (Address) Royal Theatre

15 Filed Robert F. Harrison, Registrar

SEP 15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1921, to Sept 14, 1921, that I last saw her alive on Sept 14, 1921, and that death occurred, on the date stated above, at 6 00 m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hysterectomy - (for fibroid)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 12, 1921

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) E E Duncan M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~, CREMATION OR REMOVAL Crisfield Md

DATE OF BURIAL Sept 15 1921

20 UNDERTAKER Wm. J. Dickerson & Son

ADDRESS N. Y. Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 56972 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 159 D 56972

CERTIFICATE OF DEATH.

REGISTERED No. C.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Md. General Hospital (St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman Howard Libby

(Residence in Baltimore: No. 800 N. 35th. St. (St. 2 yrs., 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug. 6, 1900
(Month) (Day) (Year)

7-AGE, 21 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 073
(a) Trade, profession, or particular kind of work: Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer): B. M. R. R.

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Jno. D. Libby

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah C. Keeser

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sarah C. Libby

(Address) 804 N. 35th. St.

15- Filed ....., 191.... Registrar.

Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gunshot wound of head,

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Hennessy M. D.
(Coroner.)

Sept. 15, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Ash St.

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Kriders Cem. Westminster Md. DATE OF BURIAL, Sept. 16 1921

20-UNDERTAKER Horace H. Burgee ADDRESS 363 Falls Rd

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

SEP 15 1921

Spec.—1-10-21—M&T—1500 Blks.

D 56973

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56973

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2911 Robes ave ST., 9. WARD)

2-FULL NAME Mary Gaye Wilmore

(a) RESIDENCE NO. 2911 Robes ave ST., WARD 9.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black.	Widowed

5a If married, widowed, or divorced (or) WIFE of William Wilmore

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or ....min.
about 49		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer) Washing Ironing

(c) Name of employer Cooking Self.

9 BIRTHPLACE (city or town) (State or country) Fredrick Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Nellie Crawford

(Address) 2911 Robes. ave

15 Filed 19 Robert P. Harrison, Registrar

15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/13. 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h alive on ....., 19.....,

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) — yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albumin in such cases

(Signed) Milligan J. Pillsbury, M. D.

9/14 1921 (Address) 609 E. 27th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Sept 16 1921

20 UNDERTAKER Jno. H. Holland

ADDRESS 1631 Druid Hill ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56974

CERTIFICATE OF DEATH.

120 D 56974

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2308 East Hoffman ST., 8 WARD)

2-FULL NAME Ellsworth McClellan Schotta

(a) RESIDENCE NO. 2308 East Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Ida Schotta

6 DATE OF BIRTH (month, day, and year) Oct 6-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector 073

(b) General nature of industry, business, or establishment in which employed (or employer) P.R.R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles F Schotta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Monsville Md

12 MAIDEN NAME OF MOTHER Margaret Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Ida Schotta (Address) 2308 E. Hoffman

15 Filed SEP 13 1921, 19 Registrar Robert F. Harrison,

Burial Permit Issued Heck 936 E. Monument

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1921, to Sept. 13, 1921.

that I last saw h[illegible] alive on Sept 14, 1921.

and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremic Convulsions (duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Wm. D. Peck M. D.

Sept 14, 1921 (Address) 936 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Sept 17 1921

20 UNDERTAKER Mellvain Cook — ADDRESS 5028 North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56975

CERTIFICATE OF DEATH.

79

D 56975

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5162 2nd St., 12 Ward)

2-FULL NAME Amelia Disney

(a) RESIDENCE No. 5162 2nd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Samuel L Disney

6 DATE OF BIRTH (month, day, and year): Nov 22/1842

7 AGE: Years 79 Months 11 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Amelia Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Albert B Disney 2nd

(Address) 5162 2nd St

15 Filed Sept 16, 1921 Robert F. Harrison, Registrar

SEP 16 1921

by John A Evans 1011 N. Carey Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 8, 1921, to Sept 15, 1921.

that I last saw he alive on Sept 14 1921

and that death occurred, on the date stated above, at 6:20 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 5 mos. 1 ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A Evans, M. D.

, 19 (Address) 1011 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cemetery — DATE OF BURIAL: Sept 16 1921

20 UNDERTAKER: William Cahalan & Bro — ADDRESS: Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 56976 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56976

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 311 Hayward Ave ST. 27 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann E Fennick

(Residence in Baltimore: No. 311 Hayward Ave St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Sept 27, 1863
(Month) (Day) (Year)

7-AGE, 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Capt. Steamboat
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, E F Fennick
11-BIRTHPLACE OF FATHER (State or Country), Maryland
12-MAIDEN NAME OF MOTHER Mary Tunsworth
13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary A Fennick
(Address) 311 Hayward Ave

15-
Filed Sept 15, 1921 Robert F. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Valvular disease of heart.
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) [signature] M. D. (Coroner.)
Sept 15, 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Woodlawn — DATE OF BURIAL, Sept 16, 1921

20-UNDERTAKER W. M. Cook — ADDRESS 707 E North Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 56977

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56977

CERTIFICATE OF DEATH.

155

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Couch

(Residence in Baltimore: No. 1826 Light St. St.; 3 yrs., ------ mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, February 27th. 1898., / (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
23 yrs. 6 mos. 18 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Street car 678.
(b) General nature of industry, business, or establishment in which employed (or employer)..... conductor.

9-BIRTHPLACE, (State or Country), Kentucky.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Couch. (wife)

(Address) 117 E. Hughes St.

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

SEP 15 1921 Burial Permit Clerk

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 14th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Ulceration of and hemorrhage into the stomach.
Bichloride of Mercury poisoning suicide. (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) ..... (Duration).....yrs.....mos.....ds.

(Signed) Wm. M. Reinhardt M. D. (Coroner.)

Sep. 15., 191. 21 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 12 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? 1826 Light St.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
National Cem.	Sept. 16, 19....
20-UNDERTAKER Wm Cook	ADDRESS 502 North a.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56978 D 56978

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: No. University Hospital ST.: 2d WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Markell

(a) RESIDENCE. No. 135 Birkhead St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~ male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 20 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frank Markell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizze Dougherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) University Hospital

15 Filed SEP 16 1921 ~~BURIAL PERMIT~~ Registrar ~~Buried .....~~ Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1921

17

I HEREBY CERTIFY, That I attended deceased from 9/9/1, 1921, to 9/15, 1921, that I last saw him alive on 9/15, 1921, and that death occurred, on the date stated above, at 2.50 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia (resulting from) subscapular abscess & Osteomyelitis of right humerus.

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Otitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes Date of 9/8/21.

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs.

(Signed) W. B. Johns, M. D.

9/15, 1921 (Address) University Hospital Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	9/17 1921
20 UNDERTAKER	ADDRESS
I. Fen McCully	130 E. Fort

mation should be carefully supplied. AGE should be stated EXACTLY. Illegible or incomplete CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Tuberculous.
Cause unknown.
Septicaemia due
to osteomyelitis &
abscess.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56979

CERTIFICATE OF DEATH.

43 D 56979

REGISTERED NO. C

1-PLACE OF DEATH Baltimore Md

CITY OF BALTIMORE, (No. 133 N. Lakewood ave St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Benson

(Residence in Baltimore: No. 133 N. Lakewood ave St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, October 26, 1874
(Month) (Day) (Year)

7-AGE. 46 yrs. 11 mos. 11 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housekeeper 037
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Frederick H. Lawrence

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Armsdorin

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William T. Benson

(Address) 133 N. Lakewood Ave

15-

Filed SEP 16 1921 191.... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 1920, to Sept 15 1921, that I saw her alive on September 14 1921, and that death occurred, on the date stated above, at 11:48 A m.

The CAUSE OF DEATH* was as follows: 0332

Carcinomatosis

(Duration) 3 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) W. H. Lawrence M. D.

Sept 15, 1921. (Address) 2439 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, Sept 17, 1921.

20-UNDERTAKER A. Sander Sons

ADDRESS 1710 Reed St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Originated in breast. Operation. Metastases to lung, other breast, head

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56980

CERTIFICATE OF DEATH.

64 D 56980

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 W. North Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel R. E. Schwatka

(a) RESIDENCE. No. 822 W. North Ave. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Schwatka

6 DATE OF BIRTH (month, day, and year) Feb. 18" 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

700

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER George B. Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co. Md.

12 MAIDEN NAME OF MOTHER Emily Moffett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md.

14 Informant Mrs. J. B. Schwatka
(Address) 822 W. North Ave.

15 Filed SEP 16 1921 19 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15" 19 21

17 I HEREBY CERTIFY, That I attended deceased from Sept 13 . 1921 . to Sept. 15 . 1921 .
that I last saw her alive on Sept. 15 . 1921 .
and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Senility Cerebral Hemorrhage
(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy Clinical symptoms

(Signed) Bernard Purnell Myers, M. D.

9/16, 1921 (Address) 1037 N. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Sept 17" 19 21
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Paca St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56981

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56981

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto General Hospital ST.; WARD)

2-FULL NAME Edward Gilasso

(a) RESIDENCE. No. 1103 Hanbert St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 10-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Gesals

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Valerya Burdinsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Valerya Gesals

(Address) 113 Holbert St

15 DATE SEP 16 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1921

17 I HEREBY CERTIFY, That I attended deceased from September 1, 1921, to September 15, 1921, that I last saw him alive on September 15, 1921, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Tetanus (Otitis)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Daniel H. Wilkerson M. D.

(Address) South Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Sept 19 1921

UNDERTAKER: Williams Fallsway & Hill — ADDRESS: 16 Hill Eastern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 56982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56982

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3401 Walbrook Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ellen Richardson

(Residence in Baltimore: No. 3401 Walbrook Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Dec 23, 1845
(Month) (Day) (Year)

7-AGE: 75 yrs. 8 mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Balto, Md.

PARENTS.

10-NAME OF FATHER: John Gibson

11-BIRTHPLACE OF FATHER (State or Country): unknown

12-MAIDEN NAME OF MOTHER: Teresa Asbourne

13-BIRTHPLACE OF MOTHER (State or Country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ebelen L. Richardson

(Address) 3401 Walbrook Ave

15- SEP 16 1921 ROBERT J. TRAUTEN
Filed ..... 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Sept 15 1921, that I saw h-r alive on Sept. 14 1921, and that death occurred, on the date stated above, at 6.30a m.

The CAUSE OF DEATH* was as follows:

arterio sclerosis — High Blood pressure — Chronic parenchimatous Nephritis

(Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) about 2 mo, yrs. ..... mos. ..... ds.

(Signed) W. S. Willett M. D.

Sept 15 1921 191... (Address) 2990 Garrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, Sept. 17 1921.

20-UNDERTAKER Joo Joerdens & Son — ADDRESS 217 S. Paca St.

N. B.—Every item of information should be given if possible. AGE must be correctly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 56983

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 56983

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1361 N Carey ST., 15 WARD)

2-FULL NAME Peter Edward Cooper

(a) RESIDENCE NO. 1361 Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Cooper

6 DATE OF BIRTH (month, day, and year) July 6, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	1	9	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Lumberyard man

(b) General nature of Industry, business, or establishment in which employed (or employer) Lathing Lumber

(c) Name of employer James Lumber Co.

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Jack Cooper

11 BIRTHPLACE OF FATHER (city or town) St Marys Co (State or country) Md

12 MAIDEN NAME OF MOTHER Elsie Thomas

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co (State or country) Md

14 Informant Mary Cooper (Address) 1361 N Carey St

15 Filed SEP 16 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1921, to Sept 15, 1921.

that I last saw him alive on Sept 14, 1921,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Surmay

(Signed) E William Frey M. D.

15, 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL Sept 19 1921

20 UNDERTAKER Lawrence E Wright ADDRESS 1364 N Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56984

CERTIFICATE OF DEATH.

151 D 56984

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen'l Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Maisel

(a) RESIDENCE. NO. 1704 W. Lexington ST., WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 9 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer 000

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Harry Le Roy Maisel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Catonsville Md.

12 MAIDEN NAME OF MOTHER Lilly Stange

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

11 Informant Harry Maisel (Address) 1704 W. Lexington

15 Filed SEP 16 1921 19... ROBERT I. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1921, Sept. 15, 1921, that I last saw him alive on Sept. 15, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endometritis.

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Arthur Edgar Tennyson, M. D.

(Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem Lutheran Catonsville	Sept 16 1921

20 UNDERTAKER Wm Lackey 826 Mosher

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56985

D 56985

CERTIFICATE OF DEATH.

80

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 S. Madeira ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Joseph Schnell.

(a) RESIDENCE: NO. 224 S. Madeira ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Margaretta Schnell.

6 DATE OF BIRTH (month, day, and year) April 1843

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Tobias Schnell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lilly Zeller
(Address) 403 So Wolfe St

15 Filed SEP 16 1921 ROBERT I KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Sep. 8. 1921. to Sep. 15. 1921, that I last saw him alive on Sep. 14. 1921, and that death occurred, on the date stated above, at 7 45 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pearrynd, M. D.

Sep. 15, 1921 (Address) 2314 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 17 1921
20 UNDERTAKER Lilly + Zeller	ADDRESS 403 So Wolfe St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56986

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56986

CERTIFICATE OF DEATH.

152

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1910 McCulloh (St.:) 14 (Ward)

2-FULL NAME Baby Harris

(a) RESIDENCE. (No.) 1910 McCulloh St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. ENTRY MUST BE MADE WITH UNFADING INK—The information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER ~~Not Given~~ Edward Harris

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Md

12 MAIDEN NAME OF MOTHER Dorothy Williams

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) Md

14 Informant Dorothy Harris
(Address) 1910 McCulloh

15 Filed SEP 16 1921, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1921 to Sept 14, 1921 that I last saw him alive on Sept 14, 1921 and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Insufficiency of Lungs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Earl Short, M. D.

9/14, 19 (Address) 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Sept 16 1921
20 UNDERTAKER John H. Joachim	ADDRESS 1412 Mt St

ROBERT I KRAUTER
Burial Permit Clerk

D 56987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 56987

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 817 S Rose ST.: Mulford Olszewski WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 817 S Rose St St.; yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Sept 17, 1921
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 3 mos. ....ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore MD

PARENTS.

10-NAME OF FATHER, Joseph Olszewski

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Marie Grabowski

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Olszewski

(Address) 817 S Rose St

15-

SEP 16 1921

Filed ....., 191.... ROBERT J. KRAUTER. Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Lynn Rood M. D.
(Coroner.)

9/16 21, 191... (Address) 1800 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus.	Sept 16" 1921.

20-UNDERTAKER	ADDRESS
M. F. Sadowski	705 S. Ann St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56988

CERTIFICATE OF DEATH.

20 D 56988

1-PLACE OF DEATH 176. N. Broadway. 13 3

CITY OF BALTIMORE: (NO. Church Home Infirmary Hosp. ST.: Above 25. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ralph S. Anthony

(a) RESIDENCE. NO. 3723 Elm Ave Baltimore ST. City WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Bessie V. Anthony

6 DATE OF BIRTH (month, day, and year) July 22, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Special officer

(b) General nature of industry, business, or establishment in which employed (or employer) Grafonola

(c) Name of employer Co.

9 BIRTHPLACE (city or town) (State or country) Talbot Co

PARENTS

10 NAME OF FATHER John W. Anthony

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co

12 MAIDEN NAME OF MOTHER Mary Rhodes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Queen Annes

14 Informant Bessie V. Anthony

(Address) 3723 Elm Ave

15 Filed SEP 16 1921 ROBERT J. KRAFFT Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1921, to Sept 15, 1921, that I last saw him alive on Sept 14, 1921, and that death occurred, on the date stated above, at 12 25 A m.

The CAUSE OF DEATH* was as follows:

Septicemia. Staphylococcus Aureus.

0732

about 10 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Broncho-pneumonia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? yes Date of Sept. 10, 1921

Was there an autopsy? Not granted.

What test confirmed diagnosis? Laboratory Culture

(Signed) W. T. Noble, M. D.

, 19 (Address) Church Home & Infirm Hosp (Ba)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Sept 8, 1921

20 UNDERTAKER: Mrs J E Evans & Sons ADDRESS 1428 N Charles St

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Exploratory operation.
Possible Rupture of Gall & Bladder
Not cancerous Neoplasm
origin unknown No further
history.

Spec.—8-24-14—M. & T.—2000 Blks.

D 56989

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 56989

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1940 Pattersn pl. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry J. Kehne

(Residence in Baltimore: No. 1940 Patterson pl. St.; Life yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should also fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	W.	Single

6-DATE OF BIRTH, March 4, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 6 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Justus Kehne

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Alberta T. Pepino

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julius Kehne

(Address) 1940 Patterson Place

15- Filed SEP 16 1921, 191.... ROBERT J. KRAUSE Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 191 , to Sept 15 1921, that I saw h.. alive on Sept 15 1921, and that death occurred, on the date stated above, at 10 40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jacob Frahm M. D.

Sept 16 1921. (Address) 1823 N. Wash. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Sept 17, 1921

20-UNDERTAKER Geo. M. Kemp & Son ADDRESS Baltimore

D. 56990 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 56990

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 607 N. Hoffman ST. 17 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Mills

(Residence in Baltimore: No. 607 N. Hoffman St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. Colrd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Sept. 13, 1921 (Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or 10 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Herman Mills

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Estu Brony

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Mills

(Address) 607 N. Hoffman St.

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

SEP 16 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) no contributory

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Kennedy M. D. (Coroner.)

Sept. 14 1921 (Address) 2502 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 19....

20-UNDERTAKER Commissioner Health.

ADDRESS SEP 1, 1921

PST. WM. S. WOODALL

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56991

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56991

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital St. 19 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Brown

(a) RESIDENCE. No. 313 Parish St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible] 1881

7 AGE: Years 40 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Moses Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Sarah Belford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Hospital Records

15 Filed SEP 1 1921, 19 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1921, to Sept 15, 1921, that I last saw h[illegible] alive on Sept 14, 1921, and that death occurred, on the date stated above, at 6 55 A m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(over)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? W D Tilson

(Signed) W D Tilson, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Sept 19 21

20 UNDERTAKER: David Easton

ADDRESS 916 Pa ave

THIS IS A PERMANENT RECORD. Every item must be formation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pelvic Inflamation
Salpingitis - Gonococcus
Infection

D 56992 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56992

CERTIFICATE OF DEATH. REGISTERED NO. C 79

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 7 Mile Lane ST.: near Park Heights Ave WARD) 27

2-FULL NAME Charles W. Brooks

(Residence in Baltimore: No. 7 Mile Lane near Park Heights Ave St.: 36 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Dec. (Month) 21 (Day) 1885 (Year)

7-AGE,	If LESS than 1 day,
36 yrs. 8 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, James Brooks

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER ? King

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura A. Brooks

(Address) 7 Mile Lane

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 14 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest and Inquiry and from.....(Autopsy or inquiry) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jabular Disease of Heart

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] (Coroner.) M. D.

Sept 15 1922 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Sept 16, 1922
20-UNDERTAKER Wm J Pickerson	ADDRESS North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should also fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 16 1922

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56993.

CERTIFICATE OF DEATH.

179 D 56993

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womens Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Estella Townsend

(a) RESIDENCE NO. 1533 Baldwin ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov- 1874

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
47	10	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory worker 086

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Pumerfield Emery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jennie Ruby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Jos Jones.

(Address) 3[illegible] Druid [illegible]

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

SEP 16 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 - 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 13, 1921 to Sept 15 1921.

that I last saw her alive on Sept 15 1921.

and that death occurred, on the date stated above, at 4:30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism ?

over

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hysterectomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 13, 1921

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. A. Duncan, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olive Randallstown

DATE OF BURIAL Sept 19 19 21

20 UNDERTAKER Wm J Tuckerton

ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item must be stated EXACTLY. PHYSICIANS should be careful to mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Mar 4370

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Retroflexion.
Hysterectomy performed
for myoma. Not
cancerous.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 56994 ✓ D 56994

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris May Mathai

(a) RESIDENCE. NO. 25 27 Druid Hill ave. ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George E. Mathai

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillian Violi Berlin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Lillian Violi Mathai
(Address) 25 27 Druid Hill Ave.

15 Filed 19 Registrar

SEP 16 1921

Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1921, to Sept 14, 1921, that I last saw her alive on Sept 14, 1921, and that death occurred, on the date stated above, at 8:15 a m.

The CAUSE OF DEATH* was as follows:

asphyxiation

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Patent foramen ovale (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Examination

(Signed) S Stanley W. Matthews, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL Sept 17 1921

20 UNDERTAKER Wm Fleckney & Sons — ADDRESS Norfolk Va

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56995 ✓ D 56995

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401-E-31st " ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily D. Heard

(Residence in Baltimore: No. 1335 N. Fulton Ave St.; 27 yrs., ✓ mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, March (Month) 29 (Day), 1860 (Year)

7-AGE, 61 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House-wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Cordova, Md.

PARENTS.

10-NAME OF FATHER, Edw. G. Davis

11-BIRTHPLACE OF FATHER (State or Country) Queen Anne Co. Md.

12-MAIDEN NAME OF MOTHER Mary E. Yes.

13-BIRTHPLACE OF MOTHER (State or Country), Talbot Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Cox (daughter)

(Address) 401 E. 31st St.

15-

Filed....., 191.....

Registrar.

SEP 16 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 15 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 9 1921, to Sept 15 1921, that I saw her alive on Sept 15 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage,
Cayenna Right Hemiplegia
Apraxia (Duration) ✓ yrs. ✓ mos. 8 ds.

CONTRIBUTORY (Secondary) ✓

..... (Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) Thos. C. Ohler M. D.

Sept 15, 1921 (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Frenlawn Md — DATE OF BURIAL, Sept 17 1921

20-UNDERTAKER Wm. J. Tichner & Son — ADDRESS Penna & Ord Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Crozier

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56996

CERTIFICATE OF DEATH

62

D 56996

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 8 E. Mt Royal ave ST.: 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Annie Cline Crozier

(Residence in Baltimore: No. 8 E. Mt. Royal ave St.; 70 yrs. 7 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Feb. 9 (Month), 1851 (Year)

7 AGE: 70 yrs. 7 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jonadiz A. Edonston

11 BIRTHPLACE OF FATHER (State or country): Washington D.C.

12 MAIDEN NAME OF MOTHER: Elizabeth Jabogues

13 BIRTHPLACE OF MOTHER (State or country): Balto Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. L. Crozier

(Address) 8 E. Mt Royal Ave

15 Harrison, Filed SEP 18 1921 191 Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 16 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30, 1921, to Sept. 15 1921, that I saw h.. alive on Sept. 15, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Tabes Dorsalis Spasmodique

(Duration) 5 yrs. mos. ds

Contributory (SECONDARY) Pneumonia Hypostatic

(Duration) yrs. 1 mos. 15 ds.

(Signed) H. J. Stricker Jr M. D.

Sept 16, 1921 (Address) 632 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: Sept 19 1921

20 UNDERTAKER: Wm. J. Tichnor & Son

ADDRESS: North & Penn

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Robert E. Burial Permit Clerk.

Remarks _____

Not Luetic.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

(Linsky) ✓

D 56997 HEALTH DEPARTMENT—CITY OF BALTIMORE D 56997

CERTIFICATE OF DEATH. 170

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Lt Crosby. Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.)

2 FULL NAME Baby Linsky.

(Residence in Baltimore: No. 1-1 Penna St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Baby

6-DATE OF BIRTH, Still Born, 1 (Month) (Day) (Year)

7-AGE, ... yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or 2 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ---
(b) General nature of industry, business, or establishment in which employed (or employer) ---

PARENTS.

9-BIRTHPLACE (State or Country), Baltimore Md

10-NAME OF FATHER Louis M. Linsky

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Lena Linsky

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Garber

(Address) 916 Penna ave

15- Robert F. Harrison,

Filed ..., 191... Registrar.

SEP 16 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 12, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound

Suicide Undetermined

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. Amos Stanley M. D. (Coroner)

(Official) (Address) 412 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ---

Former or usual residence ---

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Sept. 13, 1921

20-UNDERTAKER David Garber

ADDRESS 916 Penna

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Remarks Occupation changed from Student
at Dr. J. K. Insley's request.
Accidental. R. O. H.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer; Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., *of* .....(name origin; "Cancer" is less definite: avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage*,	*Meningitis*,	*Phlebitis*,
Cellulitis,	*Gangrene*,	*Miscarriage*,	*Pyæmia*,
Childbirth,	*Gastritis*,	*Necrosis*,	*Septicæmia*,
Convulsions,	*Erysipelas*,	*Peritonitis*,	*Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 56998

CERTIFICATE OF DEATH.

39 D 56998

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 40 S. Stare (St.:) 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floriza Ruby

(a) RESIDENCE. NO. 40 S Stare St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno Ruby

6 DATE OF BIRTH (month, day, and year) Sept 15 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Jacob Straby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Jno Ruby (Address) 40 S. Stare St

15 Filed Sept 16 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1921, to Sept 15, 1921, that I last saw h[illegible] alive on Sept 15, 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tonsil

(duration) [illegible] yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) B. O'Kelly, M. D.

, 19 (Address) 100 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Sepulcher	Sept 17 1921
20 UNDERTAKER P. Garrett & Co.	ADDRESS 1906 Eastern Ave
1906 Eastern Ave	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 16 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 56999

CERTIFICATE OF DEATH.

169

REGISTERED NO. D 56999

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 214 N. Madeira St.: 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mate Matula

(a) RESIDENCE. No. 214 N. Madeira St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Matula

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Master Matula

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Kate Macq

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Josephine Matula
(Address) 214 N. Madeira

15 Filed SEP 17 1921 Burial Permit Issued Robert J. Krauter Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 13 21, 19..., to Sept 15 21, 19...

that I last saw ... alive on Sept 15, 1921,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Krauter M. D.

Sept 16, 1921 (Address) 614 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rodeemer	Sept 17 1921
20 UNDERTAKER	ADDRESS
Frank Crack Sons	1906 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57000

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57000

CERTIFICATE OF DEATH.

REGISTERED NO. 1770

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 787 George St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Keller

(a) RESIDENCE. No. 787 George St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65	-	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheelwright

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer W. H. Lehnert

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara Schroat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. E. Keller
(Address) 787 George St.

15 Filed SEP 17 1921 19 BOUCHÉ & KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1921, to Sept. 15, 1921, that I last saw him alive on Sept. 14, 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchym. Nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Frank E. Wagner, M. D.

Sept. 15, 1921 (Address) 1101 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Sept 19 1921
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&P—1500 Bks.

Sunnie Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57001 (1476)

37 V D 57001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sunnie Smith

(a) RESIDENCE NO. 944 Mason St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 12-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Wash D. C.

PARENTS

10 NAME OF FATHER: Jeff Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Johns Hopkins Hospital Board

15 Filed SEP 17 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14-1921

17

I HEREBY CERTIFY, That I attended deceased from April 12-1921 to Sept 14-1921.

that I last saw him alive on Sept 14-1921.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Abdominal Aneurysm (Ruptured)

Syphilis

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Aug 3, 1921

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Emile Holman, M. D.

9-14-21 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Sept 17 19

20 UNDERTAKER: Felix R. Fry — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57002

151 ✓ D 57002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 White St., 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lewis Rossi

(a) RESIDENCE NO. 1925 White St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~ ~

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer ~

9 BIRTHPLACE (city or town) Balto (State or country) md

PARENTS

10 NAME OF FATHER James C Rossi

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md.

12 MAIDEN NAME OF MOTHER Mary Ross

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Ida F Fisher

(Address) 1925 White St

Filed ....., 19.... SEP 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 15, 1921, to Sept 16, 1921, that I last saw h... alive on Sept 16, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Marasmus

Malnutrition

..... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Bernard L Faust M. D.

9/16, 1921 (Address) 707 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 18 1921
20 UNDERTAKER	ADDRESS
Julia B. Pyz	1021 E. Mulberry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57003

CERTIFICATE OF DEATH.

120 D 57003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1128 Ensor. St. ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles. J. Kelly

(a) RESIDENCE NO. 1128 Ensor. St. ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May-28-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	3	19 ~~28~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Dominick Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary. Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss. Mary Kelly (Address) 1128 Ensor St

15 Filed ..... 19 SEP 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16. 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to Sept 16, 1921.

That I last saw him alive on Sept 16, 1921.

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) * Acute nephritis on Chronic (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1128 Ensor

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Chemical

(Signed) James McKenton, M. D.

9/17 1921 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Govanstown	Sept 20 1921
20 UNDERTAKER	ADDRESS
Henry Lord. Jr	139 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

57004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57004

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 E. Preston. St. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret. Katherine. Petersam

(a) RESIDENCE No. 1715 E. Preston St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred --- yrs. --- mos. 24 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug.-22-1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	------	----	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. (State or country) Md.

PARENTS

10 NAME OF FATHER Adam. J. Petersam

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret. K. Koerber

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Md.

14 Informant Mr. Adam J. Petersam
(Address) 1716 E. Preston St

15 Filed ..... 19 SEP 17 1921 Registrar .....

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-16-1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1921, to Sept 16, 1921,
that I last saw her alive on Sept 16, 1921
and that death occurred, on the date stated above, at about 9 P. m.
The CAUSE OF DEATH* was as follows:
Bronchial Catarrh

(duration) - yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank G Moyer, M. D.

19 (Address) 500 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Sept 17 1921

20 UNDERTAKER Henry Hoeck Son — ADDRESS 130 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57005 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57005

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 169

CITY OF BALTIMORE (No. U.P.D. St.: 14 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Sneidman

(Residence in Baltimore: No. 2026 Eutaw Place St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male — 4-COLOR OR RACE: white — 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): married

6-DATE OF BIRTH, June. 9., 1865 (Month) (Day) (Year)

7-AGE, 56 yrs. 9 mos. 6 ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Clothing merchant

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER, Isaac Sneidman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Wolkowitz

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lisella Sneidman

(Address) 2026 Eutaw Place

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 16, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis

(Duration) ..... yrs. ..... mos. 6 hrs. ..... ds.

CONTRIBUTORY (Secondary) Incidental Obstruction

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. J. T. Hennessy M. D. (Coroner.)

Sept. 16, 1921 (Address) 202 Edgewood Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 2026 Eutaw Place

Former or usual residence same

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Friendship	Sept 18 1921
20-UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57006

D 57006

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N. Wolfe ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Chartrue

(a) RESIDENCE. NO. 411 N. Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Chartrue

6 DATE OF BIRTH (month, day, and year): May 10-41

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Zepp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mamie Hammen

(Address) 411 N. Wolfe

19 Filed ..... 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1921, to Sept 15, 1921, that I last saw h[illegible] alive on Sept 14, 1921, and that death occurred, on the date stated above, at 6 40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Cardio Pulgson

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rosch, M. D.

Sept 16, 1921 (Address) 804 N Decatur St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept 19 21

20 UNDERTAKER: Philip Herring — ADDRESS: 2016 Orleans

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57007

D 57007

151

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Womans Hospital

CITY OF BALTIMORE: (No. Lafayette + John STA 14 WARD)

2-FULL NAME Baby Murphy

(a) RESIDENCE NO. ..... ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER J Lee Murphy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret B Cathcart

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant J Lee Murphy
(Address) 22[illegible] N. Charles St

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1921, to Sept 16, 1921,
that I last saw h[illegible] alive on Sept. 16, 1921,
and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Norman B Tannenbaum M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL 9/17/21

20 UNDERTAKER Gorsuch Sunday ADDRESS Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57008

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. Lafayette & John Hop ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby. Murphy

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 17 min.
	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ✓ ..... ✓

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER J. Lee Murphy

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret B Cathcart

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant J. Lee Murphy
(Address) 2223 N. Charles

15 Filed SEP 17 1921 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1921 to Sept 16, 1921, that I last saw him alive on Sept 16, 1921, and that death occurred, on the date stated above, at 3.10 P m.

The CAUSE OF DEATH* was as follows:

Prematurity.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? ..... no .....

What test confirmed diagnosis? .....

(Signed) Howard C Tannenbaum M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	9/17/21
20 UNDERTAKER Geo A Fahey	ADDRESS Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57009

D. 57009

CERTIFICATE OF DEATH

REGISTERED NO.....

1-PLACE OF DEATH University Hospital ST.: W WARD:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.)

2-FULL NAME Chas E. Grimes

(a) RESIDENCE. NO. Ellicott City ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs May Grimes

6 DATE OF BIRTH (month, day, and year) May 9 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Oil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Standard Oil Co. Ellicott City Md.

9 BIRTHPLACE (city or town) (State or country) Ellicott City Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Univ. Hosp. records. (Address)

15 Filed SEP 17 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1921, to Sept 16, 1921, that I last saw him alive on Sept 16, 1921, and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Thrombosis Coronary artery

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Ellicott City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs, Microscopic

(Signed) W. R. Jones, M. D.

Sept 16 1921 (Address) Univ. Hosp. Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	Sept 18 1921

20 UNDERTAKER Earl M. Slater ADDRESS Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57010

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 Aisquith St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Sandford

(Residence in Baltimore: No. 1512 Aisquith St.; ....yrs.. ....mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Sept. (Month) 15th (Day), 1921 (Year)

7-AGE. ....yrs....mos....ds. If LESS than 1 day, 1 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE. (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Clinton C. Sandford

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ruth Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sandford

(Address) 1512 Aisquith St.

15-

Filed SEP 17 1921, 191.... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 15th (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 15th 1921, to Sept 15th 1921, that I saw him alive on Sept 15 191, and that death occurred, on the date stated above, at 12 Midnight

The CAUSE OF DEATH* was as follows:

6/12 months Gestation
(Premature)

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Mother Full Term Stillborn

Interval between Onset and Death ....yrs....mos....ds.

(Signed) J. B. Kach M. D.

Sept 16 1921, 191.. (Address) 1703 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill Cem.

DATE OF BURIAL. Sept. 17 1921

20-UNDERTAKER Wm. J. E. Edmondson

ADDRESS 1498 Edmondson Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57011

CERTIFICATE OF DEATH.

4-46 D 57011

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Micheal Greely

(a) RESIDENCE. No. 426 F. St. Sparrows Point, Md. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1892

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Steel Industry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Greely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Flaharty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Union Mem. Hosp.

15 Filed SEP 17 1921 ROBERT I. CRANTON Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5th, 1921, to Sept. 16th, 1921, that I last saw him alive on Sept. 16th, 1921, and that death occurred, on the date stated above, at 5.49 a.m.

The CAUSE OF DEATH* was as follows:

Pleural Pulmonary Tbc

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sparrows Point

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George E. W. Flaherty, M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	9/19/1921
20 UNDERTAKER	ADDRESS
J. G. Moran	E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pancreas first organ involved.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 57012 — 104 — D 57012

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 430 N. Fremont Ave. ST. 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Wilson Bowen

(Residence in Baltimore: No. 430 N. Fremont Ave. St.; 1 yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Infant

6 DATE OF BIRTH August 26, 1921 (Month) (Day) (Year)

7 AGE ..... yrs. ..... mos. 27 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant dtd
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Garland Bowen

11 BIRTHPLACE OF FATHER (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Clara Pierpoint

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Garland Bowen

(Address) 430 N. Fremont Ave.

15 FILED Wed. Sept. 1921 SEP 17 1921 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 17, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1921 to Sept. 1921

that I saw h[illegible] alive on Sept 16, 1921

and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

from birth

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen C Beecham M. D.

9-17-21, 191... (Address) 3139 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oak Lawn | DATE OF BURIAL Sept 19, 1921

20 UNDERTAKER Wm Cook | ADDRESS 507 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57013

D 57013

45

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 826 E Monument ST.; 12 WARD)

2-FULL NAME John L. Mehring Sr

(a) RESIDENCE. NO. 826 E Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widower

6 DATE OF BIRTH (month, day, and year) Apl 21-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Business

(b) General nature of Industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gertrude L. Resnick (Address) 826 E Monument Ave

15 Filed SEP 17 1921, 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13 1921 to Sept 16 1921

that I last saw h[illegible] alive on Sept 16 1921

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right parotid gland

(duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of duty

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) J. E. Runtz M. D.

9/16/21 (Address) 1531 E Northern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 19 1921
20 UNDERTAKER Robt J Turner	ADDRESS 1442 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57014

CERTIFICATE OF DEATH.

64 D 57014

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hasselberger

(a) RESIDENCE. No. St. Joseph's Hosp. ST. 112 W Pleasant St WARD. St. Anns # 2

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 65 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married~~, widowed, ~~divorced~~ HUSBAND of ~~(or)~~ WIFE of Sigmund Hasselberger

6 DATE OF BIRTH (month, day, and year) April 29 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fred Hasselberger

(Address) 402 Holsom St

15 Filed SEPT 17 1921, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1921, to Sept 15, 1921

that I last saw h[illegible] alive on Sept 15, 1921

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstetial Nephritis (duralion) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What lest confirmed diagnosis?

(Signed) Frank C. Manna M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a a Co

DATE OF BURIAL Sept 18 1921

20 UNDERTAKER E & B Harke

ADDRESS 115 E Westfl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 14

D 57015

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Jen-Pri alley ST.: 5 WARD)

2-FULL NAME Laura Neal

(a) RESIDENCE. NO. 1502 Jen-Pri alley ST. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER Charles Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Lodonia Williams
(Address) 302 N Caroline St

15 Filed SEP 17 1921, 19 EG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1921, to Sept. 15, 1921, that I last saw her alive on Sept. 14, 1921, and that death occurred, on the date stated above, at 3 91 m.

The CAUSE OF DEATH* was as follows:

Amebic dysentery

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Gastric catarrh

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson M D

9/15 19 21 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Sept. 17. 1921

20 UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~50 37~~016 D 57016

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., 7 WARD)

2-FULL NAME Rebecca Roberson

(a) RESIDENCE NO. Airy Dorchester Co. Md ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 2m Hosp. 17 da yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of ~~Wm Lee~~ Patterson Md.

6 DATE OF BIRTH (month, day, and year) Dec 7 - 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	57	9	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Pattison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Sarah Dukes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 17, 1921,
that I last saw h~~is~~er alive on Sept 16, 1921,
and that death occurred, on the date stated above, at 4.15 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia - duration 1 day
Umbilical hernia - partially strangulated 12 yrs (? 6 mos)
Carcinoma fundus of uterus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 16, 1921

Was there an autopsy? No

What test confirmed diagnosis? Opration. Blood & urine analyses

(Signed) May M. Zinninger, M. D.

Sept 17, 1921 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Sept 19 1921
20 UNDERTAKER	ADDRESS
D. T. Sullivan & Son	Cambridge Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57017

CERTIFICATE OF DEATH

108 D 57017

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Rhoe.

(a) RESIDENCE. NO. 653 Redwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, (Married,) Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 35 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: not known

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Martin Rhoe

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Jane Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant: University Hosp

(Address): Records

15 Filed ..... 19 .....

Registrar

SEP 17 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1921, to Sept 14, 1921, that I last saw him alive on Sept 14, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis, with Appendiceal abscess (duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? 653 Redwood St.

Did an operation precede death? Yes Date of Sept 10, 1921

Was there an autopsy? No

What test confirmed diagnosis? Findings at operation

(Signed) W B Jones, M. D.

9/14. 1921 (Address) University Hosp. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dover N. C.

DATE OF BURIAL: Sept 17 1921

20 UNDERTAKER: R C Groot

ADDRESS: 1400 McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57018

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2832 N. Lamond St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary O'Mara

(Residence in Baltimore: No. 2832 N. Lamond St., St.; 80 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	single

6-DATE OF BIRTH, November, 1836
(Month) (Day) (Year)

7-AGE, 85 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), England.

PARENTS.

10-NAME OF FATHER, Michael O'Mara,

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Mary Copley

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cecelia Walsh

(Address) 2832 N. Lamond St

15-

Filed ....., 191... Registrar.

SEP 17 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 16, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Sept. 17, 1921 (Address) 2702 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Sept. 19 1921
20-UNDERTAKER Geo W. Little	ADDRESS 2700 Edmondson Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—)I. P. Co.— 000 Bks.

D 57019 D 57019 D 57019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (ST.:) 8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Crawford Michael

(a) RESIDENCE. (No.) 2323 Harford Ave (ST.,) (WARD.) Fairmount W. V.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 12 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dada Michael

6 DATE OF BIRTH (month, day, and year) Sept 4 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER Geo L. Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va

12 MAIDEN NAME OF MOTHER Alice McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Geo L Michael

(Address) 2323 Harford Ave

15 Filed SEP 18 1921 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1921, to Sept. 17, 1921, that I last saw h.i.m. alive on Sept. 17, 1921, and that death occurred, on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Typhoid Fever.

(duration) yrs. mos. 3 2 ds.

18 Where was disease contracted if not at place of death? Atlantic City, N.J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Widal

(Signed) Frank C. Marino M. D.

. 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmont W Va — DATE OF BURIAL Sept 19 21

20 UNDERTAKER W. Pearson Son — ADDRESS Norval

TION is very important. See instructions on

D 57020 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 127 N Schroder St. 18 WARD)

REGISTERED No. C 89

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter D Gross

(Residence in Baltimore: No. 127 N Schroder st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
Male	Colored	Single

6-DATE OF BIRTH, Sept 14, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 3 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Robt Gross

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Annie Guynn

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Monroe

(Address) 127 Schroder st

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.)

SEP 18 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... ~~Inquest, au-~~ ..... ~~topsy or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Don't Know of any

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) ..... M. D. (Coroner.)

9-18, 1921 (Address) 117 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Sept. 18, 1921

20-UNDERTAKER Jas. Bx. Skinner ADDRESS 620 E. Mad. St

N.B.—Every item of information must be given, so that it may be properly entered in the CAUSE OF DEATH in plain terms, so that it may be properly understood. All items are important. See instructions on back of certificate.

D 57021

D 57021

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2904 Keyworth Ave St. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Grunfeld

(a) RESIDENCE. No. 2904 Keyworth Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs mos. ds. How long in U. S., if of foreign birth? 33 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Mar. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

044

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Grunfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Matilda Grunfeld (Address) 2904 Keyworth Ave

15 Filed SEP 18 1921 Harry F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sep. 13 . 1921 . to Sep. 17 . 1921 . that I last saw him alive on Sept 17 . 1921 . and that death occurred, on the date stated above, at 1.35 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy).

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) David J. Macht . M. D.

Sept 17. 1921 (Address) 3420 Auchentoroly Terrace

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Sept 16 1921
20 UNDERTAKER	ADDRESS 1127 E Baltimore
Max Levinson	

mation should be given in plain terms, so that it may be clearly understood. CAUSE OF DEATH in plain terms, so that it may be clearly understood. TION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

149396
D 57022

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 50

D 57022

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Smith Walker

(a) RESIDENCE NO. Onancock Accomac Co. Virginia ST. WARD Onancock Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Lena Walker 1923 E Monument St. City.

6 DATE OF BIRTH (month, day, and year) Dec 25 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	8	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Onancock Va.

PARENTS

10 NAME OF FATHER John S. Walker

11 BIRTHPLACE OF FATHER (city or town) Accomac Co. (State or country) Va.

12 MAIDEN NAME OF MOTHER Lydia Hyslop

13 BIRTHPLACE OF MOTHER (city or town) Accomac Co. (State or country) Va

14 Informant (Address) Johns Hopkins Hosp. Reed

~~Robert P. Harrison,~~

15 Filed 19 21

Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10 , 1921 , to Sept 17 , 1921 .

that I last saw him alive on Sept. 17 , 1921 .

and that death occurred, on the date stated above, at 10½ a m.

The CAUSE OF DEATH* was as follows:

(1) Benign Prostatic hypertrophy

(2) Diabetes mellitus

(1) (duration) 4 yrs. 9 mos — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8/30/21 - 9/13/21

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene C. Shaw, M. D.

9-17, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Onancock, Va.	9/18, 1921
20 UNDERTAKER	ADDRESS
Henry U. Mears & Son	805 N. Calvert

Via Eastern Shore, Va. Steamboat line Escort - Mrs. G. B. Walker, Onancock, Va.

mation should be given. CAUSE OF DEATH in plain terms, so that TION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

See affadavit over ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57023

41 D 57023

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 677 W. Franklin St., 17 WARD)

2-FULL NAME Louis Freidman

(a) RESIDENCE NO. 677 W. Franklin St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Freidman

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or min.
65	7+			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing

(b) General nature of Industry, business, or establishment in which employed (or employer) Tailor O&S

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Friedman (Address) 677 W. Franklin St

15 Filed SEP 18 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 16, 1921, that I last saw h[illegible] alive on Sept 16, 1921, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of About 3 Yrs. ago

Was there an autopsy? No

What test confirmed diagnosis? Microscopic & Clinical findings

(Signed) Michael A. Evans, M. D.

9/18, 1921 (Address) 2360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hebron Cemetery	9/18 19 21
20 UNDERTAKER Jack Lewis	ADDRESS [illegible]

S. B. ... mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

On this 22nd, day of September of 1921, before me a Notar
of the State of Maryland, City of Baltimore, personally appeare
Jack Lewis, and made oath in due form of law that age given on
ficate # 57023 for Louis Freidman as seventy one (71) years is
rect and that the correct age is sixty five (65) years.

Jack Lewis

Morris Bogat

Notary Public 14 E Balto St.

Seal

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

150-258
D 57024

CERTIFICATE OF DEATH.

63-001 D 57024

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Cohen.

(a) RESIDENCE NO. 1714 E. Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. 7yr. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 29- 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	1	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Anna Rogerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Johns Hopkins Hosp. Records (Address)

15 Died SEP 18 1921, 19 Registrar

Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1921, to Sept. 17, 1921, that I last saw him alive on Sept. 17, 1921, and that death occurred, on the date stated above, at 7.55 a. m.

The CAUSE OF DEATH* was as follows:

Poliomyelitis Respiratory paralysis

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1714 E Fayette St

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical examination

(Signed) Bleon b. Mason, M. D.

Sept 18 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehren Rosedale DATE OF BURIAL 9/18 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Baltimore St

mation should be given in answering the following questions. Use CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57025

CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Rabnig (Rabnig or.) ST.; 4 WARD)

2-FULL NAME Josephine W Johnson St.; Life yrs., mos. ds.)

(Residence in Baltimore: No. 706 Rabnig

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Sept 1 (Month) 20 (Day), 1900 (Year)

7-AGE, 21 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Housework, (b) (General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER, Joshua Williams

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joshua Williams

(Address) 706 Rabnig St

15- Filed Aug 21 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

N. B.—Burial Permit cannot be issued until CAUSE OF DEATH in plain terms, by physician, is filed. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1921, to Sept 15 1921, that I saw h m alive on Sept 15 1921, and that death occurred, on the date stated above, at 9 P, m.

The CAUSE OF DEATH* was as follows: Tuberculosis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Ephamsis

(Duration) yrs. 1 mos. ds.

(Signed) N. Flosen M. D.

Sept 15 1921 (Address) 711 S Chapel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Sept 18, 1921

20-UNDERTAKER Jno. Geo. A. Hooper

ADDRESS 406 W. Lanvale

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57026

CERTIFICATE OF DEATH.

79 D 57026

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 121 N. Carrollton ave. WARD) 18

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Johnson

(a) RESIDENCE NO. 121 N. Carrollton ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lucy Johnson

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Prudential Oil Corp, Creese Virginia

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lucy Johnson (Address) 121 N. Carrollton ave

15 Filed SEP 18 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 24, 1921, to Sept. 14, 1921.

that I last saw h.. alive on Sept. 14, 1921,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) acute rheumatic fever. (10 yrs ago)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? none.

(Signed) Wm Francis M. D.

9/15, 1921 (Address) 121 N Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL Sept 16 21

20 UNDERTAKER Sam'l Hensley & Bro ADDRESS 1726

mation should be entered in plain terms, so that it may be properly indexed. CAUSE OF DEATH in plain terms, so that it may be properly indexed. See instructions on back of certificates. TION is very important.

D 57027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57027

CERTIFICATE OF DEATH.

REGISTERED NO. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1110 N. Carrollton Ave. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelia Foster

(Residence in Baltimore: No. 612 Carlton St. St.: 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, ... (Month) ....., 1869 (Year)

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, House wife,
(b) General nature of industry, business, or establishment in which employed (or employer), 070

9-BIRTHPLACE, (State or Country), W. Virginia

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Thompson

(Address) 1107 N. Stockton

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

SEP 1 1921 Burial Permit Clerk.

N.B.—Every item of information must be given, so that it may be proper CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage,
20 minutes
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no history
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Sept. 16 1921 (Address) 2812 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place 1110 N. Carrollton Ave. In the
of death .....yrs. .....mos. 1 dy. State.....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 612 Carlton St.

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Sept. 18, 1921

20-UNDERTAKER David J. Hennessy ADDRESS 578 N. Eutaw St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57028

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 Mc Culloh ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Banks

(a) RESIDENCE. NO. 1214 Mc Culloh ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col'd	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) April 18, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (none)

(b) General nature of industry, business, or establishment in which employed (or employer) (Nursery)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Arthur Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Mc. Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Arthur Banks 1214 Mc Culloh St.

15 Filed SEP 18 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

(over)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. T. Hennessy, M. D.

Sept. 15 1921 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 18 1921
20 UNDERTAKER	ADDRESS 5th & Bdwy
Paul J. Schneider	

B.—WRITE PLAINLY. All questions should be carefully supplied. Any information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Friday)

1920 D 57029

D 57029

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12-E 20th. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oda Frisby

(a) RESIDENCE NO. 12-E 20th. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Bl

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General housework

(b) General nature of industry, business, or establishment in which employed (or employer): Own home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Born in Balto 27 years Maryland

PARENTS

10 NAME OF FATHER: Henry Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Jennie Frisby 12-East 20th

15 Filed Sept 21 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1921 to Sept. 15 1921

that I last saw her alive on Sept. 15 1921

and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Brights Disease

In definite

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Clinical

(Signed) P. Garland Chandler M. D.

(Address) 1534-E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt-Auburn Cemetery DATE OF BURIAL Sept 18, 1921

20 UNDERTAKER: Mrs Robert A Elliott ADDRESS 1725 Ashland Ave

N. B. ... mation should be entered in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57030

D 57030

CERTIFICATE OF DEATH.

REGISTERED NO. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 S. Ann ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dominica Grazziano

(a) RESIDENCE NO. 301 S. Ann St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mariano Grazziano

6 DATE OF BIRTH (month, day, and year) June 1 - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Anthony Goglinzzi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Benedetto Ignato

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Mariano Grazziano 301 S. Ann St.

15 Robert F. Harrison, Registrar

SEP 18 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-13-1921. to 9-15-1921.

that I last saw her alive on 9-15-1921.

and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

acute Catarrhal Pneumonia —
valvular insufficiency
Chronic myocarditis.
Pregnancy 2 mo. (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) acute Cardiac dilatation (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical findings

(Signed) S. Amaro M. D.

9/16 1921 (Address) 1604 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Sept 19 1921

20 UNDERTAKER Tilly & Zeiler

ADDRESS 403 S. Wolfe

B. mation should be careful... terms, so that it may be of... CAUSE OF DEATH in plain terms, so that it may be of certif... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 57031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57031

CERTIFICATE OF DEATH.

REGISTERED NO. 54

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3909 Foster Ave ST., 26 WARD)

2-FULL NAME Rosa Anna Rainer

(a) RESIDENCE NO. 3909 Foster Ave. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Rainer

6 DATE OF BIRTH (month, day, and year) May 8-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Eligius Von Baur

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary M. Dick

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant William Rainer (Address) 3909 Foster Ave

15 Filed SEP 18 1921 .19 ... Robert T. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 12th 1921, to Sept 14th 1921, that I last saw h[illegible] alive on Sept 14th 1921, and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia (duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Ca. Adenoma (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sidney Kosen, M. D.

Sept 19, 1921 (Address) 1801 Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Sept. 19 1921

20 UNDERTAKER Lilly and Feiler.

ADDRESS 403 S. Wolfe St.

mation should be given in plain terms, so that the CAUSE OF DEATH may be understood. Indefinite and unsatisfactory answers cannot be accepted. See instructions on back of certificate. TION is very important.

(Elvira Feriolo)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57032

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Md. General Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elvira Feriolo

(a) RESIDENCE. NO. 617 S. 12th St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced (or) WIFE of — c

6 DATE OF BIRTH (month, day, and year) June 12-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3 months	3	

8 OCCUPATION OF DECEASED — c

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer — c

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Vemanzo Feriolo

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Vanessa DeAngelis

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant (Address) 617 S. 12th St Vemanzo Feriolo

15 Filed Sep 18 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7th, 1921, to Sept 17th, 1921, that I last saw h[illegible] alive on Sept 17th, 1921, and that death occurred, on the date stated above, at 12:25 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

6 weeks

CONTRIBUTORY (Secondary) Bilateral Empyema (duration) yrs. mos. ds. 4 weeks

18 Where was disease contracted if not at place of death? c

Did an operation precede death? Yes. Date of Aug 23rd '21

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Nesto di Caudera, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Sept 19 1921

ADDRESS 1038 Moffet

20 UNDERTAKER Lilly and Zeile

Back of certificate. MAKE CAUSE OF DEATH in plain terms, so that [illegible] CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 57033

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57033

CERTIFICATE OF DEATH.

81

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 Wilcox St ST., 10 WARD)

2-FULL NAME Catherine Connor

(a) RESIDENCE NO. 1039 Wilcox St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) ~~WIFE of~~ Michael Connor

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
about	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ~~None~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Cannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Martin J. Connor
(Address) 1039 Wilcox St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1920, to Sept 17, 1921.

that I last saw ~~him~~ alive on Sept 10, 1921,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenlon M. D.

9/18 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Sept 19 1921
20 UNDERTAKER	ADDRESS
Wm Cook	902 E Fayette

SEP 19 1921 Burial Permit Clerk.

mation should be given in answering this question. CAUSE OF DEATH in plain terms, so that it may be understood by a physician. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage.

2484
2788
1911

Spec.—1-10-21—M&T—1500 Bks.

D 57034

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57034

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Md ave ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME annie Passidente

(a) RESIDENCE NO. 1806 Maryland ave ST.)

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Passidente

6 DATE OF BIRTH (month, day, and year) feb 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19.	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Peter Ditiri.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Concetta Milano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) John Passidente 1806 Md Av

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

CP 18 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1921, to Sept. 17, 1921, that I last saw h[illegible] alive on Sept. 16, 1921 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Asthenia

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Yes.

(Signed) A. Palmisano, M. D.

, 19 (Address) 7 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents cem DATE OF BURIAL Sept. 20 1921

20 UNDERTAKER Wm Cook 502 E. North ADDRESS

(N. B.—Information should be carefully given, so that it may be properly entered on the permanent records. CAUSE OF DEATH in plain terms, so that it may be properly coded. Attention is called to the back of certificates. TION is very important. See instructions on back of certificates.)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57035

D 57035

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Mosher ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Wyatt

(a) RESIDENCE. NO. 1424 Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) A[illegible] 2, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. fdd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Robert Wyatt.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Rollins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Essex Co. Va.

14 Informant Robert Wyatt
(Address) 1424 Mosher

15 Filed Sept 19 1921 Robert F. Hemp 1804, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 19 21

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1921, to Sept 17, 1921, that I last saw h... alive on Sept 16, 1921, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jno. H. Magruder, M. D.

, 19 (Address) 1209 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int. Auburn Cem.	Sept 19 1921
20 UNDERTAKER George T. A. Gibson	ADDRESS 1631 Orleans Balto

N. B.—Matters should be carefully attended to, information should be carefully and fully given, so that it may be entered in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—1-9-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 57036 — D 57036

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST., 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Wynne.

(a) RESIDENCE NO. 310 East Gonzales St. Pensacola Florida ST., WARD (If non-resident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced (or) ~~HUSBAND~~ WIFE of Jack Wynne (Husband) Semi addam 1894

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or min.
26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home-wife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida.

PARENTS

10 NAME OF FATHER 2.
11 BIRTHPLACE OF FATHER (city or town) 2 (State or country)
12 MAIDEN NAME OF MOTHER 2.
13 BIRTHPLACE OF MOTHER (city or town) 1. (State or country)

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16-21 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10 - 1921, to Sept. 16 1921, that I last saw h Ealive on Sept. 16 1921, and that death occurred, on the date stated above, at 9 45 ~~PM~~ m.

The CAUSE OF DEATH* was as follows:
Brain tumor, cerebellar

History of (duration) yrs. 1/2 mos ds.
CONTRIBUTORY (Secondary) Operation; (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? Yes Date of Sept. 16 1921
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) Jay McKraw M. D.
9-17, 19 21 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montgomery Ala. DATE OF BURIAL Sept 19 1921

20 UNDERTAKER Edward Lundgold ADDRESS 1463 Penn Montgomery Ala

Burial Permit Clerk

mation should be given in plain terms, so that a CAUSE OF DEATH in plain terms, so that a CAUSE OF DEATH is very important. See instructions on back of certificate.

SEP 1921

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57037

CERTIFICATE OF DEATH.

D 57037

1491

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1809 Bell ave ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine B. Tudor

(Residence in Baltimore: No. 1809 Bell ave St.; 1 yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 16, 1920
(Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——— fdl
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, William F Tudor

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Fannie Myster

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie F Tudor

(Address) 1809 Bell Ave

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

SEP 18 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1921, to Sept 16 1921, that I saw h[illegible] alive on Sept 16 1921, and that death occurred, on the date stated above, at 11 30 p. m.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

(Duration) ....., yrs. ....., mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) ....., yrs. ....., mos. 1 ds.

(Signed) C. O. Thompson M. D.

9/13, 1921 (Address) 423 E. Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, Sept 17, 1921

20-UNDERTAKER Mrs J E Evans & Son

ADDRESS 428 E Chase

CAUSE OF DEATH to be plainly written. All items important. See instructions on back of certificate.

57038 HEALTH DEPARTMENT—CITY OF BALTIMORE 57038

D 57038 CERTIFICATE OF DEATH. X 175001 D 57038

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta A Ffeldt

(Residence in Baltimore: No. Elkridge Md St.; yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May (Month) 14 (Day), 1856 (Year)

7-AGE, 64 yrs. 4 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman affeldt

(Address) Elkridge Md

15-

Filed SEP 19 1921, 191. ROBERT J. KRAUTH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Spine, Cervical
Abrasions (Scalp & Forehead)
Internal Injuries and contusion
Accident (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Edema of Lungs
(Duration) yrs. mos. 1 ds.

(Signed) James M Tenbarge M. D.
(Coroner.)

Sept 19, 1921 (Address) 700 E Clark St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State 40 yrs. mos. ds.

Where was disease contracted, if not at place of death? Near Elkridge Md

Former or usual residence Elkridge Md.

19-PLACE OF BURIAL, OR REMOVAL, Town St. John's Lutheran — DATE OF BURIAL, Sept 20 1921

20-UNDERTAKER Easton Sons — ADDRESS Ellicott City Md.

N. B.—Every item of information must be given, so that it may be plain terms, so that it may be CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57039

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57039

REGISTERED NO. C 152

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Southern Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Muriel Beulah Greineisen

(Residence in Baltimore: No. 1505 W. Franklin St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, September (Month) 16 (Day), 1921. (Year)

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, 3 hrs. or 45 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Albert Richard Greineisen

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Beatrice Mardell Merron

13-BIRTHPLACE OF MOTHER (State or Country), Williamsport Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Beatrice M. Greineisen

(Address) 1505 W. Franklin St.

15- Filed ....., 191.... Registrar.

SEP 19 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 17 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1921, to Sept 17 1921, that I saw her alive on Sept 17 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Face presentation

(Duration) ....yrs. ....mos. ....ds.

(Cover.) (Signed) Richard Smith M. D.

9-17-21, 191.. (Address) 4518 22nd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Sept 18, 1921

20-UNDERTAKER David Easton — ADDRESS 916 Penna ave

N. B.—Every ... CAUSE OF DEATH in plain terms, ... important. See instructions on back of certificate.

Spec.—6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57040

CERTIFICATE OF DEATH.

28

D 57040

REGISTERED NO.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 2004 Guilford Ave (ST.) 17 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Blunt

(a) RESIDENCE. NO. 2004 Guilford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 27-1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	3	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Atwood Blunt
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland
12 MAIDEN NAME OF MOTHER Emily Doughty
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Atwood Blunt
(Address) 2004 Guilford Ave

15 Filed . 19 Registrar

SEP 19 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18- 1921

17 I HEREBY CERTIFY, That I attended deceased from June 28 . 1921 . to September 18 . 1921 . that I last saw h[illegible] alive on September 18 . 1921 . and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis (Chronic)

(duration) [illegible] mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) Unknown

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum - E

(Signed) [illegible] M. D.

. 19 (Address) 2439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Family Burying Ground Phoenix Md
DATE OF BURIAL: Sept 20 1921

20 UNDERTAKER: Certain & Gore
ADDRESS: 1723 N. Eutaw St.

N. B. Information should be carefully written in plain terms, so that it may be a permanent record. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 5-5-19—H. P. Co.—1000 Bks.

57041

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

VD 57041

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 So. Milton Ave. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Steve Kolasinski

(a) RESIDENCE. NO. 803 S. Milton Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 35 yrs. 0 mos. 0 ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kolasinski

6 DATE OF BIRTH (month, day, and year) Sept 18 1868

7 AGE — Years 53 Months 0 Days 0 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) American Can Co.

(c) Name of employer American Can Co.

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Wife. Mary Kolasincki 803 S. Milton Ave.

15 Filed ..... 19 ..... Registrar

SEP 19 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept.16 . 1921 , to Sept.16 . 1921 , that I last saw him alive on Sept.16 . 1921 , and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

-Apoplexy

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Artero-Sclerosis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Right side Paralysis

(Signed) E. J. Carroll M. D.

. 19 (Address) 1740 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Sept 20 1921

ADDRESS

20 UNDERTAKER Wm Fialkowski Mt Easley

mation should be given in plain terms. See that CAUSE OF DEATH is very important. See instructions on back TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9/V 57042 REGISTERED NO. C

~~57042~~

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 Grindell ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Wrengel

(Residence in Baltimore: No. 203 Grindell St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 26, 1918. (Month) (Day) (Year)

7-AGE, 3 yrs. 3 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John L Wrengel

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Emma Fulda

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L Wrengel

(Address) 203 Grindell

15- SEP 19 1921 ROBERT J KRAUTER Registrar.
Filed .... 191....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1921, to Sept 16 1921, that I saw h[illegible] alive on Sept 16 1921, and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

.... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) ....

.... (Duration) ....yrs. ....mos. ....ds.

(Signed) O H Mathias M. D.

Sept 17 1921 (Address) 1305 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Balto Co. DATE OF BURIAL, Sept 21, 1921.

20-UNDERTAKER James L Dyer ADDRESS 1409 Madison Ave

N.B.—CAUSE OF DEATH in plain language. CAUSE OF DEATH important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

57043

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57043

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mount Hope Retreat ST., 28 WARD)

2-FULL NAME Sylvan Smith

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 9 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman 166
(b) General nature of industry, business, or establishment in which employed (or employer) Dry goods
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER Dr Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Clara Ring
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Records of Mt Hope Retreat Baltimore Md.

15 Filed SEP 19 1921 19 Registrar

BOARD OF HEALTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 2nd, 1921, to Sept 18, 1921, that I last saw him alive on Sept 17th, 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

abt (duration) 1 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Melancholia

abt (duration) 0 yrs. 9 mos. 0 ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Lamury, M. D.

Sept 19, 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL Sept 19 1921

20 UNDERTAKER J. Ahrens & Co

ADDRESS 1611 Mad

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

091

64 D 57044

D 57044

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH City Hospital

CITY OF BALTIMORE: (No. 1 ST. 18 WARD)

2-FULL NAME Catherine Morgan

(a) RESIDENCE. NO. 47 S. Schroeder ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write word)
F	W	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luke Morgan.

6 DATE OF BIRTH (month, day, and year) Jan 1st 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Rodriglin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cath. Curran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hosp. Records.

(Address)

15 Filed SEP 19 1921 MORRIS A. KRAUTER Registrar Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-17 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-6 1921 to 9-17 1921

that I last saw h alive on 9-17 1921

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Hemiplegia (Cer. Hem.)

(duration) 1 yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

9-18 1921 (Address) City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Harford Rd.	Sept 20th 1921
20 UNDERTAKER	ADDRESS
J. J. Cowan & Son	901 Hollins St.

CAUSE OF DEATH in plain ... TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Name

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57045

CERTIFICATE OF DEATH.

104 N Washington Ave

REGISTERED NO. C

D 57045

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 Hooper Ave ST.; 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances adel Kearns

(Residence in Baltimore: No. 15 Hooper Ave N Washington St.; ..... yrs., 11 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)
Female	white	Single

6-DATE OF BIRTH, Nov (Month) 11 (Day), 1920 (Year)

7-AGE, ... yrs. 11 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... ✓ 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, John Kerns

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Fannie Martan

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Kerns

(Address) 15 Hooper Ave

15- Filed SEP 19 1921, 191.... ROBERT J. KRAMER Registrar.

Burial permit issued

CAUSE OF DEATH must be stated in every case. See instructions on back of certificate. Omission of important particulars will cause delay.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1921, to Sept 18 1921, that I saw h[illegible] alive on Sept 17 1921, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows: Liver

Exhaustion Malnutrition

(Duration) ..... yrs. ..... mos. 1 4 ds.

Pneumonia

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Vernon F Kelley M. D.

Sept 18, 1921 (Address) 3705 Fait Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Front Royal Va — DATE OF BURIAL, Sept 19, 1921

20-UNDERTAKER Chenowith Bros — ADDRESS Chestnut Ave

Spec.—1-10-21—M&T—1500 Bks.

57046

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57046

64

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 516 Greenmeadow ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Johnson

(a) RESIDENCE NO. 516 Greenmeadow ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Plumer Johnson

6 DATE OF BIRTH (month, day, and year) May 12 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	46	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Days work

9 BIRTHPLACE (city or town) Norfolk Co. (State or country) Va.

PARENTS

10 NAME OF FATHER Burnell Redick

11 BIRTHPLACE OF FATHER (city or town) Norfolk Co (State or country) Va.

12 MAIDEN NAME OF MOTHER Sally Redick

13 BIRTHPLACE OF MOTHER (city or town) Norfolk Co (State or country) Va.

14 Informant Willis Henry Cashburn (Address) 516 Greenmeadow

15 Filed SEP 19 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 19 21

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 19 21, to Sept 17, 19 21, that I last saw h[illegible] alive on Sept 16, 19 21, and that death occurred, on the date stated above, at 10:10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Fray M. D.

Sept 19 21 (Address) 928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Sept 20 1921

ADDRESS 142 W Hill St

20 UNDERTAKER John H. Joachim

mation should be given in plain terms, so that the CAUSE OF DEATH in plain terms, so that the CAUSE OF DEATH may be understood. See instructions on back of certificate. CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57047

CERTIFICATE OF DEATH.

151 D 57047

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3219 Vickers Road ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Emmet

(Residence in Baltimore: No. 3219 Vickers Road St.; yrs.; mos. 1/2 Hour da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Sept. (Month) 17th (Day), 1921 (Year).

7-AGE. .....yrs.....mos.....da.

If LESS than 1 day, 1 hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE. (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER. Boris Emmet

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Mabel Colf

13-BIRTHPLACE OF MOTHER (State or Country). Wisconsin

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Boris Emmet X

(Address) 3219 Victors Rd

15-

Filed.....191.....

Registrar.

CAUSE OF DEATH. This item must be answered in every case. See instructions on back of certificate. Important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 17th 1921, to Sept. 17th 1921, that I saw him alive on Sept. 17th 1921, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration).....yrs.....mos.....da.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....da.

(Signed) Louis H. Wm. Taylor M. D.

9-17, 1921. (Address) 12 York Ct.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....da. In the State .....yrs. .....mos. .....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery

DATE OF BURIAL. Sept. 19, 1921

20-UNDERTAKER Harry A. Witzke

ADDRESS 1531 W. Lombard St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57048

D 57048

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma H. Parker

(a) RESIDENCE. NO. Abbeville, S.C. ST., WARD. Abbeville S.C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Lawrence C. Parker

6 DATE OF BIRTH (month, day, and year) March 26, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER John Harriss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Susie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Laurence C. Parker (Address) Abbeville S.C.

15 Filed . 19 SEP 19 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13th, 1921, to Sept 19th, 1921, that I last saw her alive on Sept 19th, 1921, and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculer pleurisy

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cerebral tubercle

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? Abbeville, S.C.

Did an operation precede death? No Yes Date of Sept. 14, 1921

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) George B. W. Hardy, M. D.

, 19 (Address) Hon Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Abbeville S.C. DATE OF BURIAL Sept 19 1921

20 UNDERTAKER John O. Mitchell ADDRESS 120 W. Fayette St

CAUSE OF DEATH IS very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 57049

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57049

CERTIFICATE OF DEATH.

REGISTERED No. C 28

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1817 Edmondson Ave ST.) 70 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy B. Newton
(Residence in Baltimore: No. 1817 Edmondson St.: 15 yrs., 6 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F.	W.	Single

6-DATE OF BIRTH, March 15, 1906 (Month) (Day) (Year)

7-AGE, 15 yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: none (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George H. Newton.

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Mazie D. Delaney

13-BIRTHPLACE OF MOTHER (State or Country), A.A. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James E. Newton
(Address) 3404 Harford Ave

15- A EBAUTER
Filed SEP 1 1921, 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 17, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1921, to Sept. 17 1921, that I saw her alive on Sept. 16 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 10 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(Duration) yrs. 2 mos. ds.

(Signed) L. M. Lorenz M.D. M. D.
(Address) 2644 Barclay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Sept 20, 1921

20-UNDERTAKER George J. Schmidt — ADDRESS 1002 W. Lexington St.

CAUSE OF DEATH must be stated. See instructions on back of certificate. Important.

6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57050

CERTIFICATE OF DEATH.

79D 57050

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Mens Home ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward R. Pettit

(a) RESIDENCE. NO. 11800 W Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Isaac Pettit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah J McCain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mrs H W Gilman Mason

Filed SEP 19 1921 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19 21, to Sept 18 19 21.

that I last saw h alive on Sept 11 19 21.

and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date No

Was there an autopsy?

What test confirmed diagnosis?

J Norwood M. D.

(Signed)

9/19/21 (Address) 739 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Sept 20 1921

20 UNDERTAKER: George J Smith

ADDRESS 1000 W. Fayette St

Make sure that every item is answered in plain terms. CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—6-19-13—M. & T.—500 Bks.

D 57051

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57051

CERTIFICATE OF DEATH.

REGISTERED NO. C 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5014 Beauregard Av ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Percy Alfred Wingfield jr (If under 1 yr., St.: ....yrs., mos. 10 ds.)

(Residence in Baltimore: No. 5014 Beauregard Ave

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Blk	Sngl

6-DATE OF BIRTH, September 5, 1921.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
....yrs. mos. 10 ds.	....hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work.....None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. md

PARENTS.

10-NAME OF FATHER. Percy A. Wingfield jr

11-BIRTHPLACE OF FATHER (State or Country). Jamaica B. Virgin

12-MAIDEN NAME OF MOTHER Lula Gaston

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Percy Wingfield

(Address) 5014 Beauregard Ave

15- SEP 10 1921

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 18, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1921, to Sept 18 1921.
that I saw him alive on Sept 17 1921.
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Spina-bifida & Syringo-myelocele
Complete Paraplegia
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Rupture of Sac
(Duration) yrs. mos. 1 ds.
(Signed) Geo. W. Brohawn M. D.
Sept 18, 1921. (Address) 301 Sheridan Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. 10 ds. In the State yrs. mos. 10 ds.
Where was disease contracted, if not at place of death? Same
Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL. Mt Lubentz

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Samuel J. Hemsley

ADDRESS 578 W Pratt

N. B. CAUSE OF DEATH must be given in full. See instructions on back of certificate. Every question must be answered if important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57052 ✓ D 57052

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 534 N. Fulton ST., 17 WARD)

2-FULL NAME Caroline E. Douglas

(a) RESIDENCE NO. 534 W. Fulton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS'

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Douglas

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE Years 68 Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Susan Myers

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Benj. D. Douglas

(Address) 534 W. Fulton

15 Filed ..... 19 ..... SEP 19 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1921, to Sept. 18, 1921, that I last saw h[illegible] alive on Sept 18, 1921, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis 12 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage 12 hours (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Simpkins M. D.

19 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL Sept 20 1921

20 UNDERTAKER Samuel T. Dewberry ADDRESS 578 Preston

mation should be ... CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of ... ck of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

57053

CERTIFICATE OF DEATH.

REGISTERED NO. C 64

57053

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 S. Washington ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Hudzyk

(Residence in Baltimore: No. 404 S. Washington St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White	Widow

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1861. (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): At home 000

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Johan Srawk.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Anna

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary B. Churchill

(Address) 404 S. Washington St.

15- SEP 19 1921

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1921, to Sept 17 1921, that I saw h[illegible] alive on Sept. 16 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) [illegible] (Duration) yrs. mos. 1 ds.

(Signed) Geo. Heller M. D.

9-17, 1921 (Address) 1937 Eight St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, Sept 20, 1921.

20-UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann St.

CAUSE OF DEATH must be filled in. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 57054

D 57054

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Copper

(a) RESIDENCE. NO. 806 N. Milton ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Daniel LeRoy Copper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lillian B Olgen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Mrs. Lillian B. Copper 806 N. Milton Ave

15 Filed ..... 19 ..... Registrar

SEP 19 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1921, to ....., 19....., that I last saw her alive on Sept 15, 1921, and that death occurred, on the date stated above, at 2 10 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 mos)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Examination

(Signed) Stanley W. Matthews, M. D.

, 19 (Address) Maryland General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Maryland General Hospt

DATE OF BURIAL: Sept 15 1921

20 UNDERTAKER: Commissioner Health.

ADDRESS

Per Wm. E. WOODALL

Make sure that all items of information are entered on this certificate. CAUSE OF DEATH in plain terms, so that it can be understood by a layman. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Pks.

57055

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57055

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2688 St Benedict ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt. H. Baker.

(a) RESIDENCE. NO. 2688 St. Benedict ST., 20 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) 17-March-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robt Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Hannah Beyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs H Beyer

(Address) 2688 St Benedict

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 18 Sept 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1921, to Sept 18, 1921, that I last saw h alive on Sept 18, 1921, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Ac Gastr.

Enteritis

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) H. A Knell, M. D.

9/18, 1921 (Address) 4307 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn.	Sept. 21, 1921
20 UNDERTAKER	ADDRESS
Wm. Cooke	507 E. North ave

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificate.

Burial Permit Issued

SEP 19 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

57056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57056

CERTIFICATE OF DEATH.

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1534 N. Fulton ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenan Brenner

(a) RESIDENCE. NO. 1534 N. Fulton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Franklin J. Brenner

6 DATE OF BIRTH (month, day, and year) Jan-19-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John D. Kagle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Franklin J. Brenner

(Address) 1534 N. Fulton

15 Filed , 19 Registrar

SEP 19 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1921

17 I HEREBY CERTIFY, That I attended deceased from June-19-1921, to Sept-17, 1921, that I last saw her alive on Sept-17-1921, and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) Thos Jenks, M. D.

, 19 (Address) 1807 E. Rossiyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 20 1921
20 UNDERTAKER William Cook	ADDRESS 502 N Mad

CAUSE OF DEATH in plain terms, ... TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57057

CERTIFICATE OF DEATH.

X 12 ✓ D 57057

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1514 Division Street ST.. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wylie McLaughlin

(a) RESIDENCE. No. Delta, Pennsylvania ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Granville McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ida Uglie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant J. L. Norris (Address) Delta, Pa.

15 Filed SEP 19 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19, 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 14th, 1921, to Sept. 19th, 1921, that I last saw him alive on Sept 19th, 1921, and that death occurred, on the date stated above, at 1.10 A m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicemia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Perinephritic abscess

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Delta, Penn

Did an operation precede death? yes Date of Sept. 16, 1921

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) George E. Hardy M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta, Pa

DATE OF BURIAL 9/19/1921

20 UNDERTAKER Wm Cook

ADDRESS 502 E North ave

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

D 57058

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D 57058

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1905 E. Fairmount ave ST. 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Matthew Upthoff

(Residence in Baltimore: No. 1905 E. Fairmount ave St. 8 yrs. ..... mos. ..... ds.)

" " 27 years

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Single

6-DATE OF BIRTH: March 21st, 1894 (Month) (Day) (Year)

7-AGE: 27 yrs. 5 mos. 27 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Driver of
(b) General nature of industry, business, or establishment in which employed (or employer): horse and team

9-BIRTHPLACE (State or country): Baltimore Md U. S. A.

PARENTS

10 NAME OF FATHER: Henry Upthoff

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Elisabeth Reddy

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md U.S.A.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Upthoff

(Address) 1905 E. Fairmount Ave

15- SEP 19 1921 ROBERT A KRAUTER Burial Permit Clerk

Filed ..... 191.....

REGISTRAR

N. B.—Every item of information should be carefully supplied that it may be properly classified. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. ATTENTION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 20, 1921, to, Sept 16 1921, that I saw him alive on Sept 18, 1921, and that death occurred, on the date stated above, at 2.15 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) unknown yrs. ..... mos. ..... ds.

Contributory (SECONDARY): Valvular Heart disease

(Duration) unknown yrs. ..... mos. ..... ds.

(Signed) Samuel Silverstein M D

Sept 18 1921 [Address] 22 S. Broadway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Oakdale — DATE OF BURIAL: Sept 22 1921

20-UNDERTAKER: McCabe — ADDRESS: 502 E Balt

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57059

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57059

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 6 WARD)

2-FULL NAME John Henry May

(a) RESIDENCE. NO. ? Jackson Place ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna B. May

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER John H. May

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Lane

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant (Address) Hospital Records M.T.H.

15 Filed SEP 19 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1921 to Sept. 15, 1921, that I last saw him alive on Sept. 15, 1921, and that death occurred, on the date stated above, at 3.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum, X-ray

(Signed) Francis L. Badaglacco M. D.

9-15-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	SEP 19 1921 19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57060 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 57060

CERTIFICATE OF DEATH. X 104

1-PLACE OF DEATH Nursery & Child's Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. Franklin & Schroeder ST. 5 + 0 WARD.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Swartz.

(a) RESIDENCE. No. Nursery & Child's Hosp. ST. ..... WARD. .....
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred / yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26-'21.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chestertown, Md.

PARENTS

10 NAME OF FATHER John Swartz —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) JOHNS

15 Filed SEP 19 1921 Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1921.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1921, to Sept. 16, 1921, that I last saw her alive on Sept. 16, 1921, and that death occurred, on the date stated above, at 8.30 p. m.

The CAUSE OF DEATH* was as follows: Intestinal decomposition

(duration) yrs. 4 mos. 7 ds.

CONTRIBUTORY (Secondary) Convulsions —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jamel Blaine Gibbs M. D.

9/16, 1921 (Address) 706 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL, — DATE OF BURIAL SEP 19 1921 19

20 UNDERTAKER — ADDRESS

Commissioner Health.

CAUSE OF DEATH in plain terms, so that there can be no question as to its meaning. Information asked on back of certificates. TION is very important. See instructions on back.

EP 91921

Spec.—8-24-14—M. & T.—2000 Bks.

D 57061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D 57061

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 E 22 nd ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie M. Pollen

(Residence in Baltimore: No. 814 E 22 nd St.; 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1874 (Year)

7-AGE, 47 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country) Phila Pa

PARENTS.

10-NAME OF FATHER, John Zaccarini

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Pinkmann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene Pollen

(Address) 814 E. 22nd St

15-

Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk. Registrar.

SEP 191924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. (Month) 17 (Day), 1914 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1914, to Sept 17 1914, that I saw h.. alive on Sept 16 1914, and that death occurred, on the date stated above, at 8:47 A. m.

The CAUSE OF DEATH* was as follows:

..... a .....

Cerebral Hemorrhage

.....

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY .....

(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Boyer M. D.

Sept 17, 1914. (Address) 1402 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral	Sept 21, 1914

20-UNDERTAKER	ADDRESS
Austin Fahey & Son	827 N. Howard St

N.B.—Every item of information should be given, so that it may be properly entered. CAUSE OF DEATH in plain terms, so that it may be properly understood. All items important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 57062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57062

CERTIFICATE OF DEATH.

74

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2323 E Federal ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Holmes

(a) RESIDENCE NO. 2323 E Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26th 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bar Tender

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md England

12 MAIDEN NAME OF MOTHER Mary C. Forney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mary Williamson 2323 E Federal st

15 Filed SEP 19 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3rd, 1921, to Sept 18th, 1921, that I last saw h[illegible] alive on Sept 17th, 1921, and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Tumor in Temporal region of Brain (left side)

(duration) yrs. 2 mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes No Date of July 1st 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. S. Jones, M. D.

, 19 (Address) 720 N. Montford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Sept 21st 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

Should be carefully filled in plain terms, so that it may be understood by persons unacquainted with the technical terms used in certificates. See instructions on back of certificates.

CAUSE OF DEATH is very important.

Spec.—69-19—H. P. Co.—1000 Bks.

091
1582

D 57063

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57063

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #217-Club-Road. ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME KATE SHAFFER RAMSAY.

(a) RESIDENCE. NO. #217-Club-Road ST., 27 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? 65 yrs. 0 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Sept-11-1855.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Glendy Ramsay

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Littig-Shaffer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Nannie L. Ramsay (sister)
(Address) #217-Club-Road, City.

15 Filed SEP 19 1921 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1921, to Sept 18th 1921, that I last saw h alive on Sept 17th 1921, and that death occurred, on the date stated above, at 8.45 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
(Cerebral)

OVER

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis
Cancer (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Corneal Microscopic

(Signed) E. B. Gambrill Jr. M. D.

19 (Address) 24 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
GREEN MOUNT CEMETERY	Sep-20-21
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM P. MOWEN, Manager)	ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57064

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57064

42

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3830 Fall Road ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma E. Marenthimer

(Residence in Baltimore: No. 3830 Fall Road St.; 21 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Nov 8, 1853 (Month) (Day) (Year)

7-AGE, 67 yrs. 7 mos. 20 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Hanover Pa

PARENTS.

10-NAME OF FATHER, Darr

11-BIRTHPLACE OF FATHER (State or Country), Hanover Pa

12-MAIDEN NAME OF MOTHER Julia Hollitthorne

13-BIRTHPLACE OF MOTHER (State or Country), Hanover Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. William Marenthimer

(Address) 3830 Fallrood

15-

Filed....., 191..... Registrar.

Robert P. Harrison,

P 9 1921 Burial Permit Clerk.

CAUSE OF DEATH must be filled in. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1921, to Sept. 18 1921, that I saw her alive on Sept. 18 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus,

(Duration) 2 yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Asthenia

(Duration) ..... yrs. ..... mos. 7 da.

(Signed) Wm C Smith M. D.

Sept 19, 1921 (Address) 3929 Chestnut Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Ebert Cem Hanover Pa — DATE OF BURIAL, Sept 21, 1921

20-UNDERTAKER H. S. Marshall — ADDRESS 3539 Fall Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57065 ✓ D 57065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2106 W Saratoga ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Homer Hubbard Larrimore

(a) RESIDENCE. NO. 2106a Saratoga ST., WARD. Rock Hall, Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) April 16-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rock Hall Md

PARENTS

10 NAME OF FATHER Homer W. Larrimore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rock Hall Md

12 MAIDEN NAME OF MOTHER Edna Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rock Hall Md

14 Informant Homer W Larrimore (Address) 2106a Saratoga St

15 Filed Oct. 1, 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/19 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1921, to Sept 18, 1921, that I last saw him alive on Sept 18, 1921, and that death occurred, on the date stated above, at 4.45a.m.

The CAUSE OF DEATH* was as follows: Gastro Enteritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Intantile (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Estelle Hennessy, M. D.

9/19 1921 (Address) 2000 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Hall, Kent Co, Md. DATE OF BURIAL: Sept. 20 1921.

20 UNDERTAKER: Elmer W. Conklin, ADDRESS: 924 E. Eager St.

Instructions on back of certificate. CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of

SEP 19 1921 Robert J. Harrison, Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57066

64 D 57066

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 300 W Hamilton ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Dawson

(a) RESIDENCE. NO. 300 W Hamilton Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred all life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Dawson.

6 DATE OF BIRTH (month, day, and year) Feby 21 - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rebecca Kerian

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Richard A Dawson

(Address) 300 W. Hamilton ave

15 Filed ....., 19 ..... Registrar

I. E. Wehn'

CAUSE OF DEATH in plain terms. DO NOT USE ABBREVIATIONS OR TERMS OF DOUBTFUL MEANING. Fill in all blanks. Be sure to answer every question. If there is no person in attendance, or if for any reason the cause of death is unknown, this fact should be stated. If the death was due to external causes, state the accident or injury which caused it, and the date of occurrence. If from a disease of a female specific to her sex, state the age at which menstruation ceased. If the deceased was a married woman, whether single, widow, or widower, give her husband's name. If a child, state whether legitimate or illegitimate. If the deceased was a soldier, sailor, or marine, or a member of the United States Army, Navy, or Marine Corps, state the fact. If a resident of a city, the ward should be given. If the death occurred in a hospital or institution, the name should be given instead of the street and number. The information required by this certificate is necessary for the legal control of the records, and should be given by the person best informed. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1921, to Sept 19, 1921

that I last saw h.. alive on Sept 19, 1921

and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy) 1 hour

(duration) ... yrs. ... mos.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (Apoplexy) 1 hour

(duration) ... yrs. ... mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B Green, M. D.

9/19. 1924 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 22 1921
20 UNDERTAKER	ADDRESS
Mclean Cook	502 E North ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57067 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

50 D 57067

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Bartos

(a) RESIDENCE. NO. 812 N. Bradford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lost yrs. mos. ds. How long in U. S., If of foreign birth? Lo yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb 8-1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
24	7			

8 OCCUPATION OF DECEASED 015

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Bartos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Mary Bohounek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant Mary Bartos

(Address) 812 N. Bradford

15 Filed SEP 20 1921, 19.. L. E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/19/21 19

17 I HEREBY CERTIFY, That I attended deceased from 9/18/21. 19, to 9/19/21. 19, that I last saw h in alive on 9/19/21. 19, and that death occurred, on the date stated above, at 9.30 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urine & Blood

(Signed) Zobinberg, M. D.

9/19. 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	Sept 22 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E North

mation should be ... CAUSE OF DEATH in plain terms, so that a ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57068

CERTIFICATE OF DEATH.

REGISTERED NO. C 1540

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (NO. E. Monument ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Meyer Breschkin

(Residence in Baltimore: No. 2761 W. North ave St.: 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, white

5-SINGLE, (MARRIED), WIDOWED, or DIVORCED, (Write the word.) M

6-DATE OF BIRTH, Unknown (Month) (Day), 1874 (Year)

7-AGE, 47 yrs. — mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Merchant 034
(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Grocery

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Breschkin

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15- Filed SEP 20 1921, 191 Registrar.

L. E. Wohn

N. B. CAUSE OF DEATH in plain terms. important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/5 1921, to 9/19 1921, that I saw h im alive on 9/18 1921, and that death occurred, on the date stated above, at 12 50 a. m.

The CAUSE OF DEATH* was as follows:

Internal gastric hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Gastric cancer (Duration) yrs. 3 mos. ds.

(Signed) Ernest Eckartel M. D.

Sept. 19 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. 16 ds. In the State 17 yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 2761 N. North ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship

DATE OF BURIAL, 9/20, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D57069

CERTIFICATE OF DEATH.

14 57069

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Stone House Cove St. ~~Ward~~ REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Anderson

(a) RESIDENCE. NO. Stone House Cove St. 2 ~~Ward~~

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E anderson

6 DATE OF BIRTH (month, day, and year) Oct 23/1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Masonville a a co md

PARENTS

10 NAME OF FATHER John H Giochel

11 BIRTHPLACE OF FATHER (city or town) Brooklyn (State or country) Maryland

12 MAIDEN NAME OF MOTHER Canova Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edna L. Korhmann (Address) Stone House Cove a a Co Md

15 Filed ....., 19..... Registrar

SEP 20 1921 C. H. Grese

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1921, to Sept 18, 1921, that I last saw h... alive on Sept 17, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O Brooke, M. D.

, 192 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept 20 1921
20 UNDERTAKER	ADDRESS
John F Denny	715 Light St

mation and CAUSE OF DEATH in plain terms. ... TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57070

113 D [illegible]

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 N. Gay ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcus E. Markland

(a) RESIDENCE. NO. 1605 N Gay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E Markland

6 DATE OF BIRTH (month, day, and year) Nov 2 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ret'd Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Builder

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John T. Markland

11 BIRTHPLACE OF FATHER (city or town) Talbot Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Downs

13 BIRTHPLACE OF MOTHER (city or town) Kent Co Md
(State or country)

14 Informant Sarah E Markland
(Address)

15 Filed ..., 19 ... Registrar

SEP 20 1921 C. H. Cross

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1919, to Sept 19, 1921, that I last saw him alive on Sept 15, 1921, and that death occurred, on the date stated above, at 4.45 A.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterio - Sclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of

Was there an autopsy? none

What test confirmed diagnosis? –

(Signed) B. O Herzog MD, M. D.

Sept 19 1921 (Address) 1305 N Paddison Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grt Olwet

DATE OF BURIAL Sept 21 1921

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

mation should be given in plain terms. Do not use abbreviations. CAUSE OF DEATH must be stated. Every question on back of certificate TION is very important. See instructions on back of certificate.

D 57071 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57071

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. University Hospital St. V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard H. A Crawford

(Residence in Baltimore: No. 2006 Fleet st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Jan. (Month) 13 (Day), 1903 (Year)

7-AGE, 18 yrs. 8 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 631

9-BIRTHPLACE, (State or Country), Balt City

PARENTS.

10-NAME OF FATHER, John W. Crawford

11-BIRTHPLACE OF FATHER (State or Country), Balt City

12-MAIDEN NAME OF MOTHER, Anna Fusé

13-BIRTHPLACE OF MOTHER (State or Country), Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Crawford

(Address) 2006 Fleet St.

15- SEP 20 19

Filed....., 191.... I. E. Wohn Registrar.

N. B.—Every item of information must be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. CAUSE OF DEATH is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 17 (Day), 1911 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: 1

Bronchitis 2 Mercury Poisoning

(Duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Suicide

(Duration) yrs. mos. ds.

(Signed) H. X Gorman Coly M. D. (Coroner)

9-26, 1911. (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Olivet Cem	Sept. 20 1911

20-UNDERTAKER Lilly & Zeller ADDRESS 403 S. Wash. St.

...—6-9-19—H. P. Co.—1000 Bks.

Borch

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57072 41 ✓ D 57072

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 501 N Arlington Ave. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H Borch

(a) RESIDENCE. NO. 501 N Arlington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Justina Borch

6 DATE OF BIRTH (month, day, and year): Jan 20 1836

7 AGE — Years: 85 Months: 7 Days: 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Laurence Borch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Justina

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Mary Borch
(Address) 501 N Arlington Ave

15 Filed SEP 20 1921 19 E. E. Wohn Registrar

CAUSE OF DEATH ... TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17 19 21

17 I HEREBY CERTIFY, That I attended deceased from July 20, 19 21, to Sept 17, 19 21, that I last saw h... alive on Sept 17, 19 21, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Sternum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Evans M. D.

19 (Address) 101 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: 9/21/21

20 UNDERTAKER: George G Farley — ADDRESS: Fulton & Fayette

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57073 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 64 D 57073

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 Colvin ST.: 5 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Harris

(a) RESIDENCE. NO. 302 Colvin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Harris (Address) 302 Colvin St.

15 Filed SEP 20 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1921. to Sept. 17, 1921. that I last saw her alive on Sept. 17, 1921. and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson, M. D.

9/19/21 (Address) 520 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evergreen Cem.	Sept. 21 1921
20 UNDERTAKER Mrs J. G. Locks	ADDRESS 1302 Jefferson

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 57074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 091 D 57074

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Fessin ST., 17 WARD)

2-FULL NAME Teresa M Hollen

(a) RESIDENCE NO. 701 Fessin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		3	18	

8 OCCUPATION OF DECEASED None 000

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Edward Hollen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baby

14 Informant Edw Hollen

(Address) 701 Fessin St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept, 19, 1921, to Sept. 19, 1921, that I last saw h.er alive on Sept 19, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 0 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? 701 Fessin St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas Mentzer, M. D.

, 19 (Address) 221 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters — DATE OF BURIAL Sept 20th 1921

20 UNDERTAKER Hannis & Dugan — ADDRESS 1600 McCulloh

SEP 20 1921

C. I. Crese.

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Enteritis.

D 57075

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57075

CERTIFICATE OF DEATH.

X 175-002

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mersily Hospital ST.: 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gopalis

(Residence in Baltimore: No. Fleisherin a A. Co no St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Dont Know, 1 .....
(Month) (Day) (Year)

7-AGE, ... 30 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor 080
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, Stanly Gopalis

11-BIRTHPLACE OF FATHER (State or Country) Lithuania

12-MAIDEN NAME OF MOTHER, Ann Pertonte

13-BIRTHPLACE OF MOTHER (State or Country), Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos Gopalis

(Address) 2934 Eastern ave

15-

Filed ....., 191.....

SEP 20 1921

G. H. Crese. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, ~~autopsy or~~ inquiry)
thereon and from the evidence obtained by said ..... (Inquest, ~~autopsy or inquiry.~~)
.....find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Fractured Skull.....
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds. a few hours

CONTRIBUTORY (Secondary) From fore Motor Cycle

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... W. F. Gaver ..... M. D.
(Coroner)

9-20, 1921 (Address) 112 N. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Sept 21, 1921

20-UNDERTAKER John Grabianowski

ADDRESS 425 S Paca St.

N. B. CAUSE OF DEATH in plain terms, so important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57076

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57076

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 N. Madeira St.: 6 WARD)

2-FULL NAME Sarah Mathews

(a) RESIDENCE. NO. 111 N. Madeira St. WARD.

(Usual place of abode) Dur. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widowed

5a If married, widowed, divorced HUSBAND of (or WIFE of) Rider Mathews

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or — min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co Md.

PARENTS

10 NAME OF FATHER Emery Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co Md

12 MAIDEN NAME OF MOTHER Caroline Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co Md

14 Informant Wm H. Mathews (Address) 1819 Orleans St.

15 Filed . 19 Registrar

SEP 20 1921

CAUSE OF DEATH to plainly TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 17 Sept. 1921

17 I HEREBY CERTIFY, That I attended deceased from 17-8- . 1921. to 17-9- . 1921.

that I last saw h[illegible] alive on 14 4 . 1921.

and that death occurred, on the date stated above, at 5.50 p m.

The CAUSE OF DEATH* was as follows:

Nephritis, Myocarditis

Over 2 years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colon Trismond

(duration) over yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? HF

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical & Chemical

(Signed) Emmanuel Boyle . M. D.

(Address) 414 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Magothy Cemetery	Md Sept 21 1924

20 UNDERTAKER ADDRESS

Milton Davis 317 N. Eden St

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57077

28

57077

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4709 Ready Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Bond

(Residence in Baltimore: No. 4709 Ready Ave St.; 4 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Dec 23, 1871 (Month) (Day) (Year)

7-AGE, 49 yrs. 8 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 631

9-BIRTHPLACE, (State or Country), Balto Co.

PARENTS.

10-NAME OF FATHER, Wm Bond

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Catherine

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alethea Bond

(Address) 4709 Ready ave

15- G. H. Grese.

Filed SEP 20 1921 191

Registrar.

CAUSE OF DEATH. This information is required for the registration of the cause of death. Every item should be answered if possible. Physicians are urged to fill out certificates themselves. Please write plainly and use ink. Do not use lead pencil. Be particular to fill in exact location of residence and place of death. Do not return certificate to undertaker. Be sure that certificate is signed. Certificate should be mailed or delivered to Registrar of Vital Statistics within 24 hours after death occurs. Every certificate must be complete before a burial permit will be issued. Please read carefully the instructions printed on the back of certificate. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 18 1921, to Sept 18 1921, that I saw him alive on Sept 17 1921, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs Duration 4 yrs
Lobar pneumonia Nephritis

(Duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(Duration) yrs. mos. 3 ds.

(Signed) G. W. Bishop M. D.

Sept 18, 1921. (Address) 501 Sheridan Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Fork, Balto Co — DATE OF BURIAL, Sept 21, 1921

20-UNDERTAKER Philip Henry — ADDRESS 2016 Orleans

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57078

D 57078

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

A 1-PLACE OF DEATH US PHS Hosp. #56

CITY OF BALTIMORE: (NO. Fort McHenry Baltimore Md ST., 7th X 28 WARD)

2-FULL NAME Ramon Santayo

(a) RESIDENCE NO. US PHS Hosp. #56 Fort McHenry ST. Baltimor WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) ----

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ------

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER ----

11 BIRTHPLACE OF FATHER (city or town) (State or country) ----

12 MAIDEN NAME OF MOTHER ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ----

14 Informant Edgar T Rosenbrock Registrar
(Address) US PHS Hosp. #56 Balto. Md.

15 Filed SEP 20 1921 , 19 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18. 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4, , 19 21 , to Sept. 18, , 19 21.

that I last saw him alive on Sept. 18, , 19 21,

and that death occurred, on the date stated above, at 7'10 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronicpulmonary far advance. & active.

April 4,/21 (duration) ---yrs. ---mos. ---ds.

CONTRIBUTORY (Secondary) ---- (duration) ---yrs. ---mos. ---ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinic report

(Signed) Thomas B. Payne M. D.
Senior Surgeon (R)

9/18 1921 (Address) US PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

20 UNDERTAKER Sol Levinson

DATE OF BURIAL Sept 20 1921

ADDRESS 1127 E. Balto St

CAUSE OF DEATH in plain terms. See instructions on back of certificate. ATION is very important.

Spec. 140 21 M&S 1500 Blks.

D 57079

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57079

CERTIFICATE OF DEATH.

24 X 167

1-PLACE OF DEATH US. PHS Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellery L Rhoades

(a) RESIDENCE NO. US. PHS Hosp. #56 Fort McHenr ST., Baltim WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Skilled workman

(b) General nature of industry, business, or establishment in which employed (or employer): Edgewood Arsenal

(c) Name of employer: ----

9 BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10 NAME OF FATHER Isa c Rhoades

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar
(Address) US PHS Hosp. #56 Balto, Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1921, to Sept. 19, 1921, that I last saw him alive on Sept. 19, 1921, and that death occurred, on the date stated above, at 8'30 A.m.

The CAUSE OF DEATH* was as follows:

Burns, of head face chest back both arms & forearms both thighs & legs.

over

Sept. 16/21 (duration) --yrs. mos --ds.

CONTRIBUTORY (Secondary) ---
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Edgewood Md.

Did an operation precede death? nO Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clini[illegible]port

(Signed) Thomas B. Paynter M.D.
Senior Surgeon (R)

9/19 1921 (Address) US PHS Hosp. #56 Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pattinsburg Mo.

DATE OF BURIAL: Sept 20 1921

20 UNDERTAKER: Sol Linnson

ADDRESS (2) E. Balto

CAUSE OF DEATH in plain terms, so ... TION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Industrial accident at Edgewood Arsenal

57080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 79 57080

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1503 Lafayette St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Emma Rodgers

(Residence in Baltimore: No. 1503 Lafayette St.; yrs., Lifetime mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Married

6-DATE OF BIRTH: Sept (Month) 30th (Day), 1858 (Year)

7-AGE: 62 yrs. 11 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 837

9-BIRTHPLACE. (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Carston E. Schultze

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): John F. Rodgers

(Address): 1503 E. Lafayette Ave.

15-

SEP 20 1911 C. H. Grese.

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 16 (Day), 1911 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. Ashby Ingles M. D. (Coroner)

9-17, 1911. (Address) Mt. Vernon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem.	9/21, 1911
20-UNDERTAKER	ADDRESS
Geo. F. Evans Son & Co	118 W. Mt. Royal ave

N. B.—Every item of information must be given in plain terms, so that it may be understood by the people. CAUSE OF DEATH in plain terms, so that it may be understood by the people. CAUSE OF DEATH important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 57031

10 30 PM

150774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57031

71

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 26 WARD)

2-FULL NAME Vernon Swingler

(a) RESIDENCE NO. 3706 E Lombard St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Andrew & Margaret Swingler. Same address.

6 DATE OF BIRTH (month, day, and year) Sept. 4 1921.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Andrew Swingler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret D. Slate

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed SEP 20 1921 19 G. W. Crose Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1921 to Sept 19, 1921, that I last saw him alive on Sept 19, 1921, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(cause undetermined)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) none —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? hospital —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? —

(Signed) Horace G. Stewart M. D.

9/20, 1921 (Address) Johns Hopkins Hospital —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	Sept 20 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 E. Eager

CAUSE OF DEATH must be plainly written. TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Blks.

D 57082

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57062

38

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 7 Chapanoke Road 21 WARD)

2-FULL NAME Joseph Diamond.

(a) RESIDENCE NO. 7 Chapanoke Road ST., Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Elizabeth Diamond

6 DATE OF BIRTH (month, day, and year) June 26 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	-	-	

066

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Polish Company.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER Joseph Diamond.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER T. Diamond.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant John Diamond. (Address) No 7. Chapanoke Road

15 Filed SEP 20 1921, 19 L. E. Wehr] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 18, 1921, that I last saw h[illegible] alive on Sept 18, 1921, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Phthisis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Chas Jones M. D.

1921 (Address) 4206 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery.	Sept. 21 1921

20 UNDERTAKER George F. Ruth ADDRESS 1735 Harford ave

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57083

57083

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 101 Winter ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia means

(a) RESIDENCE. NO. 101 Winter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William means

6 DATE OF BIRTH (month, day, and year) Feb 8 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Keys

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Samuel Ward (Address) 1131 Race St.

15 Filed ....., 19.. G. H. Grese. Registrar

CAUSE OF DEATH in plain ... TION is very important. See instructions on back of ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/17/21 19

17 I HEREBY CERTIFY, That I attended deceased from 6/14/ 19 21, to 9/17/ 19 21, that I last saw h... alive on 9/16/ 19 21, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation about 6 mos. — undetermined

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Jno Bowley, M. D.

9/19/ 21 (Address) 1908 E Shard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 20 1921
20 UNDERTAKER Samuel Handley Ward	ADDRESS 39 E

57084

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

158 D 57084

1-PLACE OF DEATH

CITY OF BALTIMORE (No Morgue ST: 13 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Leonard Haus

(Residence in Baltimore: No. 2802 Woodbrook Ave. St. Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH. — — 1883
(Month) (Day) (Year)

7-AGE. 38 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Kansas, U.S.A.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Betty Haus

(Address) 2802 Woodbrook Ave

15-

Filed ....., 191.....

G. H. Grese

Registrar.

N. B. CAUSE OF DEATH in plain terms is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) investigation and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned by Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Gau M. D.
(Coroner)

Sept 22, 1921 (Address) 1800 Eastland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount	Sept. 20, 1921
20-UNDERTAKER	ADDRESS
Wm Cook	502 E North ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57085

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 57085

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 N Carey ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles N Dasch

(a) RESIDENCE. No. 325 N. Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Dasch

6 DATE OF BIRTH (month, day, and year) Dec 28 - 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76.	9.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. F. Dasch. 325 N Carey St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19th 21

17 I HEREBY CERTIFY, That I attended deceased from Sept 17th 1921, to Sept 19th 1921, that I last saw him alive on Sept 19th 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis Chronic (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of x

Was there an autopsy? no

What test confirmed diagnosis? Presumptive

(Signed) W. Ken Williams, M. D.

, 19 (Address) 681 Cresaptown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Sept. 21 1921

20 UNDERTAKER: William Cook — ADDRESS 502 E Hirth Av

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

SEP 20 1921 H. Crese

Spec.—8-24-14—M. & T.—2000 Bks.

D 57086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57086

28

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3815 Falls Road ST.; 13 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agatha Gladys Grimes
(Residence in Baltimore: No. 3815 Falls Road St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
~~3-SEX~~ Female	White	Single

6-DATE OF BIRTH. June (Month) 30 (Day), 1904 (Year)

7-AGE. 17 yrs. 7 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Scholar
(b) General nature of industry, business, or establishment in which employed (or employer): ~~Home~~

9-BIRTHPLACE. (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Not Given

11-BIRTHPLACE OF FATHER (State or Country). Not Given

12-MAIDEN NAME OF MOTHER Elizabeth Grimes

13-BIRTHPLACE OF MOTHER (State or Country). Edmonton Ky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Susan Grimes
(Address) 3815 Falls Rd

15-
Filed SEP 20 1921, 191.....
G. H. Grese
Registrar.

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September (Month) 19 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1921, to Sept 19 1921, that I saw h[e] alive on Sept 19 1921, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines

(Duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Brandt M. D.
..... 191... (Address) 1718 E. Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. Woodlawn Cemetery — DATE OF BURIAL. Sept 22, 1921

20-UNDERTAKER H S Marshall — ADDRESS 353 Falls Rd

Spec.—1-10-21—M&T—1500 Bks.

57087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57087

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 E. Eager St. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor. E. Mueller

(a) RESIDENCE NO. 1611 E. Eager St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry. G. Mueller

6 DATE OF BIRTH (month, day, and year) March 3-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Abbottston. York. Co. Pennsylvania.

PARENTS

10 NAME OF FATHER George. Litz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Sarah. Heidler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mr. Henry G. Mueller

(Address) 1611 E. Eager St.

15 Filed SEP 20 1921, 19 SEP 30 1921 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept.-18-1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 1921 to Sept 18 1921.

that I last saw h alive on Sept 18 1921.

and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. S. Gray, M. D.

9/7, 1921 (Address) 6 yr ave and Ken

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery, DATE OF BURIAL Sept. 21 1921

20 UNDERTAKER Henry Hoeck & Son ADDRESS 130, E E

CAUSE OF DEATH in plain terms, so that any person can understand. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57088

D 57088

CERTIFICATE OF DEATH.

41

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 839 St. Fremont Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Robinson

(a) RESIDENCE. NO. 839 St. Fremont Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Robinson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt City

PARENTS

10 NAME OF FATHER: Robt Bishop

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt City

12 MAIDEN NAME OF MOTHER: Litia Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt City

11 Informant (Address): Mrs Eastman 539 St Carroll Ave

15 Filed . 19 C. H. Grese. Registrar

SEP 20 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 1921 to Sept 19 1921, that I last saw h[illegible] alive on Sept 18 1921, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Duodenum.

CONTRIBUTORY (Secondary) Acute Myocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin Murray M. D.

. 19 (Address) 1211 W. Lafayette Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery DATE OF BURIAL: Sept 21 1921

20 UNDERTAKER: Graham N. Walker ADDRESS: 723 W Lafayette ave

CAUSE OF DEATH in plain terms. See instructions on back of Certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57089

HEALTH DEPARTMENT—CITY OF BALTIMORE

57089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 6 WARD)

REGISTERED NO. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Stewart

(a) RESIDENCE. NO. 1711 Mullikin St; ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18 Yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) House Girl

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md;

PARENTS

10 NAME OF FATHER Wm H. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Goldsborough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records
(Address)

15 Filed SEP 20 1921, 19 SEP 20 1921 Registrar
O. H. Crese.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 17th, 1921, to Sept 18th, 1921, that I last saw her alive on Sept 18th, 1921, and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. L. Dadaglieres, M. D.

(Address) Municipal Tbc Hosp. 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 21 1921
20 UNDERTAKER	ADDRESS
Chas G Bailey	1422 Edmondson Ave

CAUSE OF DEATH TION is very important. See instructions on back

pec.—6-9-19—H. P. Co.—1000 Bks.

D 57090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 57090

REGISTERED NO.

1-PLACE OF DEATH Homewood Apt

CITY OF BALTIMORE: (No. Charles & 31st St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Jane Graham Shaffner

(a) RESIDENCE. No. Homewood Apt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced (write the word): Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE: about 70 — Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER Mr Hanna Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Island

12 MAIDEN NAME OF MOTHER Catherine Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: George D. Graham
(Address): Homewood Apt

15 Filed ....., 19 .....

C. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 3rd, 1921, to Sept 19, 1921, that I last saw h.e alive on Sept. 18, 1921, and that death occurred, on the date stated above, at 2 am.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Arteria Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William S Baer, M. D.

. 19 (Address) 4. E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 20 1921

20 UNDERTAKER: Henry A Jenkins Son Co — ADDRESS: Edmondson Ave Catonsville Md

CAUSE OF DEATH. See instructions on back. TION is very important.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

D 57091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57091

CERTIFICATE OF DEATH.

6 120

REGISTERED NO.....

1-PLACE OF DEATH Church Home + Infirmary

CITY OF BALTIMORE: (NO. 126 N. Broadway ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Nina Duvall

(a) RESIDENCE. NO. Church Home + Infirmary ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) invalid 15 yrs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lemuel E. Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) md,

12 MAIDEN NAME OF MOTHER Mary J Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Duvall Sis.

(Address) 1600 E. Cary St.

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

20 1921

CAUSE OF DEATH. See instructions on BACK. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19. 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1921, to Sept 19, 1921, that I last saw h er alive on Sept 19, 1921, and that death occurred, on the date stated above, at 5.15 p. m.

The CAUSE OF DEATH* was as follows:

mitril stenosis,

insuffiency

chronic interstitial nephritis

(duration) 3 yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical examinations

(Signed) W. D. Noble, M. D.

, 19 (Address) Church Home + Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Olivet Sept 21, 1921

20 UNDERTAKER ADDRESS

1201 W. Fayette St. John Oursler

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57092

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Madison ave ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Edith Earleckson

(a) RESIDENCE. No. 1502 Madison ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced WIFE of (or) HUSBAND of: single

6 DATE OF BIRTH (month, day, and year) June 7. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Dr. Edwin Earleckson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Martha A. Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Celia E. Duvall

(Address) 1502 Madison ave

15 Filed Sep 19 1921 Robert P. Harrison, Registrar

Vital Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 17th, 1921, to Sept 20th, 1921, that I last saw her alive on Sept 19th, 1921, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination of sputum

(Signed) Edwin K. Ballard, M. D.

, 19 (Address) 1622 Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mound — DATE OF BURIAL: Sept 22 1921

20 UNDERTAKER: John O. Mitchell — ADDRESS: 120 W. Fayette St

CAUSE OF DEATH. See instructions on back of this certificate. IMPORTANT. The following information is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57093 ✓ D 57093

CERTIFICATE OF DEATH.

29

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3730 Gough St. ST., 26 WARD)

2-FULL NAME Agnes E. Connelly.

(a) RESIDENCE NO. 3730 Gough St. ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Aug 6 - 1899

7 AGE: Years 22 Months 1 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer): Crown Cork & Seal Co.

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: John P. Connelly.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. City.

12 MAIDEN NAME OF MOTHER: Emma E. Wolf.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): John P. Connelly 3730 Gough St.

15 3-10-21 19 Robert P. Hartigan Registrar

P 20 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Sep 1, 1921 to Sep 18, 1921. that I last saw h er alive on Sep. 18, 1921. and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 21 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) E. L. Pennington M. D.

Sep. 19, 1921 (Address) 2314 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: Sept. 22 1921

20 UNDERTAKER: Lilly and Zirkus

ADDRESS: 403 S. Broadway

CAUSE OF DEATH must be plainly written. See instructions on back of Certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D 57094

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57094

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 S. Clinton ST., 26 WARD)

2-FULL NAME Joseph Loeffler.

(a) RESIDENCE NO. 730 S. Clinton St ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kunigunda Loeffler.

6 DATE OF BIRTH (month, day, and year) Aug 31 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	56	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. O&D

(b) General nature of industry, business, or establishment in which employed (or employer) James Lumber Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Joseph Loeffler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Kunigunda Loeffler. (Address) 730 S. Clinton St.

15 Filed ..., 19... Robert P. Harrison, Registrar

Burial Permit Clerk.

P 2 0 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Sept 18, 1921.

That I last saw him alive on Sept 18, 1921,

and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Thomas B. Tuthill, M. D.

9/20. 1921 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem

DATE OF BURIAL Sept 21 1921

20 UNDERTAKER Tilly and Zeile

ADDRESS 403 S. Wolfe

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57095

CERTIFICATE OF DEATH.

15 V D 57095

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 252 N. Biddle ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Names.

(Residence in Baltimore: No. 252 N. Biddle St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Sept. (Month) 18 (Day), 1921 (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, ...hrs. or 3 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Franklin Names.

11-BIRTHPLACE OF FATHER (State or Country), Bahama Islands

12-MAIDEN NAME OF MOTHER Viola Chandler

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....Robert F. Harrison.....Registrar.

SEP 20 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 18 1921, to Sept. 18 1921, that I saw h.e alive on ....., 191....., and that death occurred, on the date stated above, at 6:40 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. J. Rigney M. D.

....., 191... (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY

DATE OF BURIAL. SEP 20 1921, 191...

20-UNDERTAKER Commissioner Health

ADDRESS

For Wm. F. WOODALL

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57096

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Williams

(a) RESIDENCE. No. 30 B S Brighton ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Eugene Leon Williams

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rena Winn Fiske

13 BIRTHPLACE OF MOTHER (city or town) Boston
(State or country) Mass.

14 Informant Mrs. Rena Fiske Williams
(Address) 3035 Brighton St.

15 Filed SEP 20 1921 Robert F. Harrison, M.D.
Registrar

P 20 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1921, to Sept 20, 1921, that I last saw him alive on Sept 20, 1921, and that death occurred, on the date stated above, at 2 45 a m.

The CAUSE OF DEATH* was as follows:

Prematurity (6½ months)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John G Johnson M. D.

, 19 (Address) 1127 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	SEP 20 1921

20 UNDERTAKER	ADDRESS
Commissioner Health. per. Wm. H. WOODALL	

CAUSE OF DEATH ... TION is very important. See instructions on ...

Spec.—1-10-21—M&T—1500 Blks.

150611
D 57097

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 104 -091 ✓ D 57097

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Johns Hopkins Hospital ST., 9 WARD)

2-FULL NAME ~~Thomas~~ Norma Lucille Smith

(a) RESIDENCE NO. Street, Harford Co. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Street Harford Co. Md

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Curtis E. Smith

6 DATE OF BIRTH (month, day, and year) Jan. 8, 1921.

7 AGE: Years ..... Months 8 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Curtis E. Smith

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Sadie L. Diffendarfer

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed ..... 19 ..... Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1921, to Sept 20, 1921, that I last saw her alive on Sept 20, 1921, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos 56 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? x-ray

(Signed) Horace G. Stewart, M. D.

9/20, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shrewsbury Pa — DATE OF BURIAL Sept 23 1921

20 UNDERTAKER H. L. Bailey — ADDRESS Darlington Md

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

02 01921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57098

CERTIFICATE OF DEATH.

120

D 57098

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Aged of the M E Church St. 22 WARD)

2-FULL NAME Maria L. Blakely.

(a) RESIDENCE. NO. S W Cor Franklin St and Fulton Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 037

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Herman Oppelt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Caroline Michael

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Helen E Bennett

(Address) Home for the Aged M E Church

15 Filed Sep 20 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

EP 20 1921

CAUSE OF DEATH. ATTENTION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1921

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to Sept 19, 1921, that I last saw her alive on Sept 18, 1921, and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH* was as follows:

Chronic Stephritis Interstitial

(duration) 3- yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ✓ yrs. 6 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Usual methods

(Signed) Geo A Shannon, M. D.

19 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sep 21 1921
20 UNDERTAKER	ADDRESS 1000 Fayette
George J Smith	

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57099

D 57099

CERTIFICATE OF DEATH.

100

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 Cumberland ST.: 77 WARD)

2-FULL NAME Eldridge Reese

(a) RESIDENCE. NO. 602 Cumberland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 1 mos. ds. How long in U. S., if of foreign birth? 4 yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 19, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Walter H. Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Alma J Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Walter H. Reese
(Address) 602 Cumberland St

15 Filed 19 Robert P. Harrison, Registrar

P 201921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1921, to Sept 19, 1921, that I last saw h[illegible] alive on Sept 19, 1921, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Vincents Angina
Edema of Glottis
Edema of Lungs
(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Cardiac Arthenia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? "

What test confirmed diagnosis? Physical

(Signed) Edw V. Carlahan, M. D.

19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 9/21 19

20 UNDERTAKER George J. Smith

ADDRESS 1000 N Fay

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57100 ✓ D 57100

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Eastern Ave St. V Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Lavina~~ Fultz

(Residence in Baltimore: No. 1816 Eastern Ave. St.; 23 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. August 28, 1898
(Month) (Day) (Year)

7-AGE. 23 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): D.37

9-BIRTHPLACE. (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER. Andrew German.

11-BIRTHPLACE OF FATHER (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER Bessie C Tedrin

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Wm. Fultz

(Address) 1816 Eastern Ave.

15- Robert P. Harrison,

Filed ..... 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 20, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14 1921, to Sept 20 1921, that I saw h M alive on Sept 14 1921, and that death occurred, on the date stated above, at 5:15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis bothers.

(Duration) yrs. mos. 15 ds.

(Signed) J. Dunbeck M. D.

, 191... (Address) 1826 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oak Lawn. Pa

DATE OF BURIAL. (June 23) 191...

20-UNDERTAKER E & B Hale

ADDRESS 115 E Ave St

Cross out words not important. See instructions on back of certificate.

2 (1192)

D 57101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57101

CERTIFICATE OF DEATH.

159

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3704 Falls Road WARD 25)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elias G Shinkle

(Residence in Baltimore: No. 3704 Falls Road St. 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 21, 1862 (Month) (Day) (Year)

7-AGE, 52 yrs. 5 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 019

9-BIRTHPLACE, (State or Country) Carroll Co Md

PARENTS.

10-NAME OF FATHER, Elias Shinkle

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co Md

12-MAIDEN NAME OF MOTHER Mary Shelton

13-BIRTHPLACE OF MOTHER (State or Country) Frederick Co Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie A Shinkle

(Address) 3704 Falls Rd

15- Filed , 191 Registrar.

N. B. Every item of information should be given in this CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by myself (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun Shot wound Shooting Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Signed (Coroner) M. D.

Sept 20 1921 (Address) 3612 Reed

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Cemetery DATE OF BURIAL, Sept 21 1921

20-UNDERTAKER, Wm Cook ADDRESS 502 E Madison

SEP 20 1921

Carrie Moses

D 57102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57102

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1036 E. Fort Ave. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Paszkowski. 30 -------- (St.; yrs., mos. ds.)

(Residence in Baltimore: No. 1036 E. Fort Ave.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, January 1st. 1883. (Month) (Day), 1 (Year)

7-AGE, 38 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Saloon keeper.
(b) General nature of industry, business, or establishment in which employed (or employer): 044

9-BIRTHPLACE. (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Joseph Paszkowski.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Mary.----------

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Paszkowski. (wife)

(Address) 1036 E. Fort Ave.

15- Robert P. Harrison,

Filed ..... 191..... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 19th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Sep. 20..., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Sept. 22 1921

UNDERTAKER William Paczkowski — ADDRESS 1018 Eastern Ave.

CAUSE OF DEATH in plain terms. Be sure to answer all questions. Every item important. See instructions on back of certificate.

SEP 20 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57103 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57103

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST.: Municipal Tuberculosis Hospital WARD) 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kruszelnicke

(a) RESIDENCE. NO. 1502 Grace Court, Curtic Bay ST. WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Kruszelnicke

6 DATE OF BIRTH (month, day, and year) 1 90 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 197

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Wojtk Masur

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Kydy Masur

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Hospital Records M. T. H.

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

Burial Permit Clerk.

20921

CAUSE OF DEATH ... TION is very important. See instructions on back of ... k of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1921, to Sept. 19, 1921, that I last saw her alive on Sept. 18, 1921, and that death occurred, on the date stated above, at 12.40 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculoma of Brain

(duration) ..... yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 1 yrs. 4 mos. ds.

18 Where was disease contracted, if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Badger M. D.

9-19-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	Sept 21 1921
20 UNDERTAKER	ADDRESS
Jacob Frankowski	425 S. Bond St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

) 57104

CERTIFICATE OF DEATH.

119 D 57104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 Barnes ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sherman Sudler

(Residence in Baltimore: No. 1712 Barnes St.; 23 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown, 1 ..... (Month) (Day) (Year)

7-AGE, 45 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer Q.M.D.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Somerset Co., Md.

PARENTS.

10-NAME OF FATHER, Freeborn Sudler

11-BIRTHPLACE OF FATHER (State or Country), Somerset Co. Md

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Percy Collins

(Address) 605 N. Bond st

15- Filed SEP 21 1921, 191..... Registrar.

CAUSE OF DEATH. This information is required for the registration of the fact of death and is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 19th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 24 1921, to Sept. 19 1921, that I saw him alive on Sept 10 1921, and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Bright Disease

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Haematuria & Albuminuria

(Duration) yrs. 2 mos. ds.

(Signed) W. C. Sandbeck M. D.

Sept. 19, 1921. (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL. Sept 21 1921

20-UNDERTAKER John W Henderson

ADDRESS 1503 E. Monument

Not tuberculous. Could give no history as to what caused acute nephritis

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57105

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 57105

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 Paca st (Mt Winans) 25 WARD)

2-FULL NAME Marie Chambers

(a) RESIDENCE. NO. 35 Paca st Mt Winans WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Chambers

6 DATE OF BIRTH (month, day, and year) Dec 15 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Theodore Seefeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mr. Ernest Chambers 35 Paca st (Mt Winans)

15 Filed SEP 21 1921 19.. E. Webb Registrar

CAUSE OF DEATH in plain terms, ... TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/20/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 9/3/ 1921 to 9/20/ 1921.

that I last saw her alive on 9/19/ 1921.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

CONTRIBUTORY (Secondary) Pulmonary T-B (duration) 2 yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathology

(Signed) J. B. Hawkins M. D.

9/20/ 1921 (Address) 1216 E. H. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Sept 22 1921.

20 UNDERTAKER James Pigman & Son — ADDRESS 1008 S. Paca St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57106 ✓

D 57106

CERTIFICATE OF DEATH.

1920

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 Mondawmin ST., 45 WARD)

2-FULL NAME Bernard Sherry

(a) RESIDENCE NO. 2228 Mondawmin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Naomi Sherry

6 DATE OF BIRTH (month, day, and year) 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Isaac Sherry Russia

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant .....
(Address) .....

15 Filed SEP 21 1921, 19 ..... I. E. Wehn Registrar

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1921

17 I HEREBY CERTIFY, That I attended deceased from June ....., 1921, to Sept 20, 1921, that I last saw h.... alive on Sept 20, 1921, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chr. nephritis; Arterial Sclerosis

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Medical Witness, M. D.

, 19 (Address) 2340 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehren Herring Run — DATE OF BURIAL 9/21 1921

20 UNDERTAKER Jack Lewis 1411 E Balto St — ADDRESS

Pruschak ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57107

97

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 Curley St ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Christina Pruschak

(a) RESIDENCE. NO. ~~37~~ 512 N. Curley ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~~5~~ yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of John Pruschak

6 DATE OF BIRTH (month, day, and year) Aug 4-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER — Druschke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER — ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Hildebrandt (Address) 512 N Curley St.

15 Filed SEP 21 1921 Registrar I. E. Webb

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1921, to Sept 19, 1921, that I last saw her alive on Sept 19, 1921, and that death occurred, on the date stated above, at 7.45 a.m. Sept 20.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis A. W. Krauss, M. D.

, 19 (Address) 2500 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept 23 1921

20 UNDERTAKER J Herwig & Co

ADDRESS 2008 Eden

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

57108

HEALTH DEPARTMENT—CITY OF BALTIMORE

57108

CERTIFICATE OF DEATH.

REGISTERED NO. C 175-

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. John Hopkins Hosp ST.: 6 WARD)

2-FULL NAME Leon Plotkin St.: Life yrs., mos., da.)

(Residence in Baltimore: No. 12 N Washington st

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	S

6-DATE OF BIRTH, April — (Month) (Day), 1914 (Year)

7-AGE, 7 yrs. 4 mos. da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work School (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Abrohum Plotkin

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Ida Parshitz

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto st

15- SEP 21 1921

Filed ....., 191.... Registrar.

I. E. Wehn

N.B.—EVERY CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. da.

(Signed) H. Louis Grutzner M. D. (Coroner)

9-21, 1921 (Address) 4 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

In the At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Hebrew Russdale | DATE OF BURIAL, Sept 21, 1921

20-UNDERTAKER Jack Lewis | ADDRESS 1411 E. Balto

D 57109 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D 57109

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 202 S Clinton ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salvatore Marino

(Residence in Baltimore: No. 202 S. Clinton St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	M

6-DATE OF BIRTH, March (Month) 10, (Day) 1865 (Year)

7-AGE, 66 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tinsmith
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dealer

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Joseph Marino

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Nd Simon

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Marino

(Address) 202 S Clinton St

15- Filed SEP 21 1921, 191.... Registrar.

N. B.—Every item of the CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Henry Tyler Kirkland M. D.
(Coroner)

Sept 21, 1921 (Address) 800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Holy Redeemer — DATE OF BURIAL, Sept 23 19 21

20-UNDERTAKER Wendell Coppedge Son — ADDRESS 37 E Saratoga St

D 57110 HEALTH DEPARTMENT—CITY OF BALTIMORE 182 D 57110

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH
CITY OF BALTIMORE (No. Hospital ST.: 10 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George A Skinner St.; yrs., mos. da.)

(Residence in Baltimore: No. 913 E madison

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE. 52 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laborer 040

9-BIRTHPLACE. (State or Country). Eston Shore Md

PARENTS.

10-NAME OF FATHER, Charles Skinner

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Elnor Skinner

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nollie Skinner
(Address) 715 E Madison

15-
Filed SEP 21 1921, 191.....
J. R. Wehn Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., Sept 19, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach Ulcer

..... (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... da.

(Signed) ..... (Coroner) M. D.

9-20, 1921. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Sept 23, 1921

20-UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Av

D 57111 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57111

CERTIFICATE OF DEATH. 33

REGISTERED No. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. 900 Shuter St.; 7 WARD)

1 FULL NAME Alvin Hill

(Residence in Baltimore: No. 900 Shuter St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life

St.: yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 23 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country). Born in Baltimore

PARENTS.

10-NAME OF FATHER. Charles H Hill

11-BIRTHPLACE OF FATHER (State or Country). born in Md

12-MAIDEN NAME OF MOTHER Hattie Wilson

13-BIRTHPLACE OF MOTHER (State or Country). Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Hill

(Address) 900 Shuter St

15-

Filed SEP 21 1921 19.. L. E. Wahn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 1 (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epithelioma of Neck

Duration 4 mos.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) ..... M. D. (Coroner)

9-21, 1921 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Asbury Cem

DATE OF BURIAL, Sept 21, 1921

20-UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

N.B.—Entries on this CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

D-57112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-57112

37

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Wright

(a) RESIDENCE NO. 1934 ~~Broadway~~ Broad St. ST., 9th WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9th 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	10	8	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Scott Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eileen Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/19 — 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 16 . 1921 . to Sept 19 . 1921 . that I last saw him alive on Sept 19 . 1921 . and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Hereditary syphilis

(duration) 11 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Wassermann Reaction,

(Signed) Horace G. Stewart M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill, Md.

DATE OF BURIAL Sept. 22 1921

20 UNDERTAKER James H. Dennis

ADDRESS 1303 Greenmount

CAUSE OF DEATH must be written in plain English. See instructions on back of certificate. TION is very important.

Size—6-8-19—H. P. Co.—1000 Blks.

D 57113

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57113

CERTIFICATE OF DEATH. X 4 51 D 57113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Devilbiss

(a) RESIDENCE. NO. Walkersville, Md, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of mr. David Devilbiss

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Albaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital records. (Address)

15 Filed SEP 21 1921 19 T. E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 1921, to Sept 21 1921, that I last saw h.er alive on Sept 21 1921, and that death occurred, on the date stated above, at 6:55 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Thyroidectomy.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Toxic Goitre (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Walkersville Md.

Did an operation precede death? Yes Date of Sept 20, 1921

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) K. B. Jones, M. D.

Sept 21 1921 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet- Frederick Md	9/23 1921
20 UNDERTAKER	ADDRESS
O C Carty	Frederick Md.

mation should be entered in plain terms, so that it may be clearly understood. CAUSE OF DEATH in plain terms, so that it may be clearly understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

D 57114

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57114

CERTIFICATE OF DEATH.

168-002

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 5 N Exeter ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy D. Markell.

(Residence in Baltimore: No. 5 N Exeter St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May 12 (Month), 12 (Day), 1921 (Year)

7-AGE, ... yrs. 4 mos. 8 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Chester Markell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Verda Rice

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mr. Chester Markell
(Address) 5 N. Exeter St.

15- SEP 21 1921
Filed ....., 191.... T. E. Wehn Registrar.

N.B.—Every question must be answered, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept. (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.), find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: 0727

Asphyxia (Accidental)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Lodes M. D. (Coroner)

Sept 21 1921 (Address) 1431 E Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Balto. City. DATE OF BURIAL, Sept 21, 1921

20-UNDERTAKER J. A. Moran ADDRESS 3000 E. Balto St.

Stone—6-9-19—H. P. Co.—1000 Blks.

D 57115 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 120 D 57115

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1732 McCulloh ST.: 14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dixon

(a) RESIDENCE. NO. 1732 McCulloh St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lettie Dixon.

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - 040

(b) General nature of industry, business, or establishment in which employed (or employer) Handling freight

(c) Name of employer Canton S. Ship Co.

9 BIRTHPLACE (city or town) (State or country) Virginia not given Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER not given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lettie Dixon (Address) 1732 McCulloh

SEP 21 1921 Registrar

L. E. Wahn

CAUSE OF DEATH. See instructions on back. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1921, to Sept 20, 1921, that I last saw h~~im~~ alive on Sept 20, 1921, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

ac. uremia } Paralysis agitans
} Encephalitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Periodic Motor Paralysis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Cannot Say

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Urinary.

(Signed) Edw. Short M. D.

9, 20, 1921 (Address) 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Sept 22 1921

20 UNDERTAKER James H. Dennis ADDRESS 213 Preston

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably ~~old~~ tetanus chronic nephritis

Spec.—1-10-21—M&T—1500 Bks.

D 57116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57116

CERTIFICATE OF DEATH.

91

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 S. Robinson ST., 1 WARD)

2-FULL NAME Joseph Lamella

(a) RESIDENCE NO. 216 S. Robinson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Lamella

6 DATE OF BIRTH (month, day, and year): Sept. 1856

7 AGE — Years: 65 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Custom Shoe

(b) General nature of industry, business, or establishment in which employed (or employer): Maker 084

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Joseph Lamella

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosa Bova

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Joseph Lamella 216 S. Robinson St.

15 Filed SEP 21 1921, 19 ..... I. E. Wehn Registrar

1604 N. Fenlinson

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-18-1921

17 I HEREBY CERTIFY, That I attended deceased from 9-17-, 1921, to 9-18-, 1921, that I last saw h[illegible] alive on 9-18-, 1921 and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows: Broncho pneumonia acute.

(duration) yrs. mos 1 dys. acute

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs. mos. 1 dys.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Microscopic - Health Department - M. D.

(Signed) S. Snyder

9-21 1921 (Address) 1604 Fenlinson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Sept 22 1921

20 UNDERTAKER: J. A. Moran — ADDRESS 3000 E Baltimore

CAUSE OF DEATH in plain terms, so that CERTIFICATE is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 57117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57117

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2224 Columbus Ave ST. 71 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen R Harper

(a) RESIDENCE NO. 2224 Columbus Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Harper

6 DATE OF BIRTH (month, day, and year): Oct 14 1857

7 AGE: Years 63 | Months 11 | Days 5 | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 37

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Francis Holloway

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Charlotte Wade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Harper

(Address): Washington Park

15 Filed ..... 19 ..... Robert F. Garrison, Registrar

Burial Permit Clerk.

P 21 192

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-19 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-15, 1921, to 9-19, 1921, that I last saw her alive on 9-19, 1921, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

debility

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Valvular Heart disease

Cardiac insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) J. Strahl M. D.

, 19 (Address) Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Sept 22 1921

20 UNDERTAKER: Wm Fleischmann Sons

ADDRESS: Baltimore

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57118 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57118

42

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto. General Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence A. Affayroux

(a) RESIDENCE. NO. 1205 N. Chester ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 7. 1871.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Epaulette Affayroux

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Martha Watts

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant (Address) South Baltimore Gen. Hospital 1213 Light St Baltimore.

15 Filed SEP 21 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1921

17 I HEREBY CERTIFY, That I attended deceased from September 11. 1921, to September 20. 1921, that I last saw h.er alive on September 20. 1921, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma of Left Ovary

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Sept 29-1921.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Temple Rubert Williams M. D.

, 19 (Address) South Balt General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 19

20 UNDERTAKER Wm J. Nicholson & Son

ADDRESS North Ave

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.--1-10-21--M&T--1500 Bks.

D 57119

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57119

113

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 Eutaw Place ST., 11 WARD)

2-FULL NAME William Kemp Perkins Jr.

(a) RESIDENCE NO. 1325 Eutaw Place ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced (cr) WIFE of: Mary McCay Perkins

6 DATE OF BIRTH (month, day, and year) Aug. 11-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	58	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Attorney at Law

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William H. Perkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Parlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Mary Mc Perkins

(Address): 1325 Eutaw Place

15 Filed ..... 19..... Registrar

P 2 1 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Year, 1917, to September 20, 1921,

that I last saw him alive on September 20, 1921,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cirrhosis of the Liver

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Arteriosclerosis Aortic Heart

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. H. L. Mayer M. D.

Sept. 20 1921 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Sept 24 1921

20 UNDERTAKER: Wm Lackenbour — ADDRESS: Fr. Pa

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

body at city morgue - 28D 57120

D 57120 HEALTH DEPARTMENT—CITY OF BALTIMORE

to be buried Sept

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. on Way to Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Chas Moore

(Residence in Baltimore: No. 634 Burgundy st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Dont Know

6-DATE OF BIRTH, ... Dont Know, 1 .....
(Month) (Day) (Year)

7-AGE, 40 about yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dont know
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Dont Know

PARENTS:

10-NAME OF FATHER ( )

11-BIRTHPLACE OF FATHER (State or Country). ( )

12-MAIDEN NAME OF MOTHER ( )

13-BIRTHPLACE OF MOTHER (State or Country). ( )

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed ..... 19.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept 13 , 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

From History I think
Pulmonary Tuberculosis
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Gorsuch M. D.
(Coroner.)

9.17, 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, SEP. 20 1921

20-UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health,
By Wm. F. WOODALL.

CAUSE OF DEATH to be filled in plainly and completely. All items important. See instructions on back of certificate.

SEP 21 1921

(Burial Permit Clerk.)

body at city morgue

D 57121 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57121

CERTIFICATE OF DEATH. 4 19 REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.))

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 684 Josephine St St. 4 WARD)

2-FULL NAME Mrs Hurd

(Residence in Baltimore: No. 684 Josephine st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Dont Know

6-DATE OF BIRTH, ... Dont Know (Month) 1 (Day) ..... (Year)

7-AGE, 30 about yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, " "

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Son

(Address) .....

15- Filed ....., 191.... Robert F. Hartley Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

..... (Duration) dont Know yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) dont know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

9-19, 1921 (Address) 117 N Dallas St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL ..... DATE OF BURIAL, ..., 19....

20-UNDERTAKER per Wm E. WOODALL ADDRESS .....

Commissioner Health

CAUSE OF DEATH in plain terms, as much as important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND SET

APR 2 1921

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57122

63-001

D 57122

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4223 Belview ave ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Carroll Clifford Jr

(Residence in Baltimore: No. 4223 Belview ave St.; 3 yrs., 9 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH. Nov 22, 1917. (Month) (Day) (Year)

7-AGE. 3 yrs. 9 mos. 32 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Chas Carroll Clifford

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Ruth M. Hoffocker

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. C. Clifford

(Address) 4323 Belview Ave.

15- Filed SEP 21 1921, 191.... Robert F. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 21, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1921, to Sept 21 1921, that I saw him alive on Sept 20 1921, and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis
(Acute anterior poliomyelitis)
* Definite symptoms about 10 hours prior to death (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)..... (Duration)....yrs....mos....ds.

(Signed) H. B. Emerson M. D.

9-21, 1921. (Address) 2016 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet Cem. DATE OF BURIAL. Sept. 1921.

20-UNDERTAKER Joseph L. B. Cook ADDRESS 1003 N. Bond St.

IMPORTANT. See instructions on back of certificate.

Rpmc.—6-9-19—H. P. Co.—1000 Bks.

D 57123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57123

43

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 N. Stricker St. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Eney

(a) RESIDENCE. NO. 824 N. Stricker ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 1 mos. 30 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William H. Eney

6 DATE OF BIRTH (month, day, and year) July 20" 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	1	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Columbus Tuttle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Anna J. Tuttle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Walter S. Eney 824 N. Stricker St.

15 Filed Sept 22 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

P 21 1921

CAUSE OF DEATH to be filled in plainly. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19" 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1920, to Sept 19 1921, that I last saw h[illegible] alive on Sept 19 1921, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Chas A. Schaefer M. D.

Sept 22 1921 (Address) 53 S. Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Sept 22" 1921

20 UNDERTAKER: Joseph L. B. Cook ADDRESS: 1003 N. Eutaw St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

VD 57124

D 57124

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 E. 20th. St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie E. Pedro

(a) RESIDENCE. No. 216 E. 20th. St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph F. Pedro

6 DATE OF BIRTH (month, day, and year) Mch. 21, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Joseph Tidkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Fannie Sibley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Albert Pedro 216 E. 20th St.

15 Filed Sept 21 1921 Robert F. Harrison, Registrar

Daniel R. Wall, Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1921, to Sept 19, 1921, that I last saw h e alive on Sept 19, 1921, and that death occurred, on the date stated above, at 8,30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock from fall down Stairs (duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. B. Britton, M. D.

Sept 20 1921 (Address) 1711 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Sept. 22, 1921
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway,

CAUSE OF DEATH should be carefully filled out. See instructions on back of certificate. TION is very important.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57125

D 57125

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen. Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustavus Matey

(a) RESIDENCE. No. 802 W. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Mulatto	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 8 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5 months	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas A. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Teresa Matey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Teresa Matey (Address) 1826 E. Lombard St.

15 Filed Robert F. Harrison, Registrar

SEP 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20. 1921. to Sept 20. 1921.

that I last saw him alive on Sept 20. 1921.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism Delirium tremens

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nesta DeCordre M. D.

. 19 (Address) Md. Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents Cemetery

DATE OF BURIAL Sept 21 1921

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W. North Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57126 ✓ D 57126

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Barrett

(a) RESIDENCE. NO. 1532 John ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or partirular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Gerald W. Barrett

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Eleanor H. Jones.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Eleanor H. Barrett.
(Address) 1532 John St.

15 Filed Robert T. Harrison, 19 Registrar

Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 19

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1921, to Sept. 20, 1921, that I last saw her alive on Sept 20, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) Stanley W. Matthews, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 21 1921

ADDRESS

20 UNDERTAKER Commissioner Health.

Per. Wm. F. Woollett

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

88

21 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57127 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57127

CERTIFICATE OF DEATH. 109

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Owens.

(a) RESIDENCE. NO. 1011 Wharton ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walker Owens.

6 DATE OF BIRTH (month, day, and year) June 24, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Melvin Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ellen Brooks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Walker Owens (Address) 1011 Wharton Street

15 Filed 21 1921 . 19 Robert F. Harrison. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 . 1921 . to Sept 19 . 1921.

(that I last saw her alive on Sept 19 . 1921.

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows: Strangulated Umbilical Hernia. -

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Aspiration Fecal matter under anaesthetic. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis M. Tinko, M. D.

. 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Market, St. Mary's Co. Md.	Sept. 22 1921

20 UNDERTAKER James H. Dennis ADDRESS 1303 Greenmount

CAUSE OF DEATH. See instructions on back of CERTIFICATE. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57128

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57128

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 229 arch ST.: 4 WARD)

2-FULL NAME Estella Sherwood

(a) RESIDENCE. NO. 229 arch ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Launderess

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore - Md

PARENTS

10 NAME OF FATHER Henry Sherwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dorothy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Unknown

14 Informant Mary E Newman

(Address) 229 arch St

15 Filed SEP 22 1921

G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15th, 1921, to Sept 18, 1921, that I last saw h[illegible] alive on Sept 18, 1921, and that death occurred, on the date stated above, at 12 00 M. m.

The CAUSE OF DEATH* was as follows:

Consumption

Pulmonary

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Miscellaneous

(Signed) Samuel A Bani M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Sept 22 1921

20 UNDERTAKER Daniel Easton

ADDRESS 916 Eutaw

CAUSE OF DEATH. See instructions on back of this certificate. ATTENTION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 57129 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57129

47

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 N. Broadway ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Worden

(a) RESIDENCE NO. 1629 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH: In plain words, do not use abbreviations or technical terms. See instructions on back of certificate. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James D. Worden

6 DATE OF BIRTH (month, day, and year) April 14-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	69	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Delta

(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Thompson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Louise Biggs

13 BIRTHPLACE OF MOTHER (city or town) Delta

(State or country) Md

14 Informant Mrs. J. H. Batty

(Address) 1629 N. Broadway

15 SEP 22 1921

Filed . 19 J. B. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1921, to Sept 20, 1921, that I last saw h[illegible] alive on Sept 20, 1921, and that death occurred, on the date stated above, at 4.15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus

(duration) yrs 13 mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Dr James A O'Donnell M. D.

9/26 1921 (Address) 1026 Mct St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept 22 1921

20 UNDERTAKER H. Sander & Sons

ADDRESS 1710 Eden St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

144 D 57130

REGISTERED NO. D 57130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Clarence Wyshaw (Mary)

(a) RESIDENCE. No. Confederate Woman's Home Baltimore

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Clarence Wyshaw

6 DATE OF BIRTH (month, day, and year) Dec. 18, 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Williamson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Dalton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hosp Records

15 Filed . 19 SEP 22 1921 Registrar

I. E. Weber

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1921, to Sept. 20, 1921, that I last saw her alive on Sept. 20, 1921, and that death occurred, on the date stated above, at 3.05 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Retro peritoneal abscess.

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? Partial autopsy.

What test confirmed diagnosis?

(Signed) George C. W. Bartlett, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Sept 23 1921

20 UNDERTAKER Henry W. Jenkins Sons Co

ADDRESS McCulloh & Orchard

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57131

CERTIFICATE OF DEATH.

37 D 57131

REGISTERED NO.

1-PLACE OF DEATH for Hebrews

CITY OF BALTIMORE: (No. Hebrew aged Home ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Cohen

(a) RESIDENCE No. 2201 E Balto st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Cohen

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1411 E Balto st

15 Filed SEP 22 1921, 19 I. E. Wehn Registrar

CAUSE OF DEATH must be stated in plain English. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/21 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1921, to Sept 20, 1921, that I last saw h[illegible] alive on Sept 20, 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

uremia - Sprue two.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Samuel Rabinowitz M. D.

, 19 (Address) 1342 W Mount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 9/22 1921

20 UNDERTAKER Jack Lewis 1411 E Balto st

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57132

CERTIFICATE OF DEATH.

170 D 57132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 N. Durham ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Smith

(a) RESIDENCE. No. 1020 N. Durham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE 60 Years	Months —	Days —	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector 07

(b) General nature of industry, business, or establishment in which employed (or employer) Collector

(c) Name of employer —

9 BIRTHPLACE (city or town) born in Va
(State or country) Lic in Baltimore 17 years

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mary Hudson Smith
(Address) 1020 N Durham st

15 Filed SEP 22 1921 Registrar
L. E. Wohn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1921, to Sept 20, 1921, that I last saw him alive on Sept 19, 1921, and that death occurred, on the date stated above, at 6.25 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis? urinalysis

(Signed) H. S. McCard, M. D.

9/20 1921 (Address) 2000 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Sept 23 1921

20 UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57133

HEALTH DEPARTMENT—CITY OF BALTIMORE

57133

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 W. Royal Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Climena Stein

(a) RESIDENCE. No. 1413 W. Royal ST., 14 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 66 yrs. 11 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Stein

6 DATE OF BIRTH (month, day, and year) Oct-5-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Easton

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Henry Lowrey

11 BIRTHPLACE OF FATHER (city or town) Van Leuvenville

(State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Selina A. Van Leuven

13 BIRTHPLACE OF MOTHER (city or town) Van Leuvenville

(State or country) Massachusetts

14 Informant Mr Adam Stein - (husband)

(Address) 1413 W. Royal Ave

15 Filed SEP. 22 1921 I. E. Wolff

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1915, to Sept 21, 1921, that I last saw her alive on Sept 21, 1921, and that death occurred, on the date stated above, at 8.35 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Erwin F. Magee, M. D.

Sept. 22 1921 (Address) 1438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Sept 23 1921
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH ... See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

80 D 57134

D 57134

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 Ridgewood Road ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Patterson Graham

(a) RESIDENCE. NO. 102 Ridgewood Rd ST., 27 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 53 yrs. 5 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Riggs Graham

6 DATE OF BIRTH (month, day, and year) April-7-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer 42

(b) General nature of industry, business, or establishment in which employed (or employer) Law

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Salisbury Maryland

PARENTS

10 NAME OF FATHER Sam'l A. Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carlisle Penna

12 MAIDEN NAME OF MOTHER Louisa Collier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Salisbury Maryland

14 Informant Mrs Caroline R. Graham (wife)

(Address) 102 Ridgewood Road

15 SEP 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1921, to Sept. 21, 1921, that I last saw h[illegible] alive on Sept. 21, 1921, and that death occurred, on the date stated above, at 8-15 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

1 hour

(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pain in chest

(Signed) Edwin M. Gilson Porter, M. D.

9/21/1921 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Sept 23 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Assistant)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 57135

HEALTH DEPARTMENT—CITY OF BALTIMORE

164 D 57135

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 S Milton ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ryshard L Sowienski

(a) RESIDENCE NO. 828 S Milton ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanley J Sowienski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Agatha Stettin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanley Sowienski
(Address) 828 S Milton ave

15 Filed SEP 22 1921 L. E. Wehn Registrar

CAUSE OF DEATH
TION is very important See instructions on back of certificate

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Sep 19 1921 to Sep 21 1921.

that I last saw h[illegible] alive on Sep 21 1921.

and that death occurred, on the date stated above, at 3.0 p. m.

The CAUSE OF DEATH* was as follows:

Acut gastro enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J Valentine, M. D.

Sept. 22 1921 (Address) Fair Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Sep 22 1921

20 UNDERTAKER John A Weber — ADDRESS 1803 Bank St

Spec.—1-10-21 M&T 1500 Bks.

D 57136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57136

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1841 N.Milton Ave. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma G.Luken

(a) RESIDENCE NO. 1841 N.Milton Ave. ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ August W.Luken

6 DATE OF BIRTH (month, day, and year) July 8th, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md.

PARENTS

10 NAME OF FATHER John Grindel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Dollinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clarence Luken (Address) 1841 N.Milton Ave.

15 Filed SEP 22 1921 John'l Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept.20th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19th, 19 21, to Sept 20th, 19 21, that I last saw h[illegible] alive on Sept 20th, 19 21, and that death occurred, on the date stated above, at 9P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Unknown (duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) By Chronic Amanuensis, M. D.,

, 19 (Address) Helen D. Owen 1841 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Sept.23, 21

20 UNDERTAKER Edw.I.Fanning & Son, 1938

ADDRESS E.Lafayette

CAUSE OF DEATH: See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57137

D 57137

CERTIFICATE OF DEATH.

119

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 161 W. Hamburg ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Gaines

(a) RESIDENCE. No. 161 W. Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46 yrs.	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) House Cleaning

(c) Name of employer Mr. Jos. Chaffee

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm. Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Mary Ann Soden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Waldorf Md

14 Informant Mary Ross (Niece)
(Address) 161 W. Hamburg St

15 Filed SEP 22 1921 19 I. E. Woran Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15 1921, to Sept. 20 1921, that I last saw h[illegible] alive on Sept. 20 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
(Exposure)

(duration) 1 yrs. mos. 21 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary test

(Signed) J. L. Shelton, M. D.

19 (Address) 203 W. Hamburg St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hillen Tubwy Cemt.	Sept 23, 1921
20 UNDERT. J. L. Brown & Son	ADDRESS 501 Park Ave

CAUSE OF DEATH TION is very important. See instructions on back of certificate

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57138 ✓ D 57138

CERTIFICATE OF DEATH.

D 57138

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Katherine P. Frizell

(a) RESIDENCE NO. Webster ST., WARD Westminster Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~ Widowed

5a If ~~married~~, widowed, ~~or divorced~~ (w) WIFE of Howard D. Frizell

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife. DD

(b) General nature of industry, business, or establishment in which employed (or employer): Housekeeping

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westminster, Md

PARENTS

10 NAME OF FATHER: George Arbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll County

12 MAIDEN NAME OF MOTHER: K. P. Arbaugh.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll County.

14 Informant: Ada. A. Bowers
(Address): 22 [illegible] Baltimore, Md

15 Filed [illegible], 19 Registrar

CAUSE OF DEATH: See instructions on back of certificate. TION is very important

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13. 1921. to Sept 22. 1921. that I last saw her alive on Sept 22, 1921. and that death occurred, on the date stated above, at 2.05 A m.

The CAUSE OF DEATH* was as follows:

Peritonitis !

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Hysterectomy (for Cancer)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept. 19.

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) E E Duncan, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Md — DATE OF BURIAL: Sept 22 1921

20 UNDERTAKER: H Monroe Routson — ADDRESS: 228 N [illegible]

Spec.—1-10-21—M&T—1500 Blks.

57139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57139

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1125 N. Bond. St. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna. Berger

(a) RESIDENCE NO. 1125 N. Bond St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Berger

6 DATE OF BIRTH (month, day, and year) Feb.-23-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	27	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mr. George Berger (Address) 1125 N. Bond St

15 Filed ..... 19 SEP 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept.-20-1921

17 I HEREBY CERTIFY, That I attended deceased from July 2 1921 to Sept 20 1921.

that I last saw her alive on Sept 20 1921.

and that death occurred, on the date stated above, at 11.20 a.m. M

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease.
Mitral Regurgitation.

(duration) yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) William Frazer M. D.

9/22 1921 (Address) 1407 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery.

DATE OF BURIAL Sept. 23 1921

20 UNDERTAKER Henry Hoch & Son

ADDRESS 1901 E Eager

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

57140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. D 57140

1-PLACE OF DEATH Howard Kelly Hosp.

CITY OF BALTIMORE: (NO. 1418 Eutaw Place ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Pegues

(a) RESIDENCE. NO. Mansfield La. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lelia Nabors Pegues

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Post Master

(b) General nature of industry, business, or establishment in which employed (or employer) Mansfield La

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mansfield La

PARENTS

10 NAME OF FATHER Wm J. Pegues

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Elizabeth Gibbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mansfield La

14 Informant (Address) J. N. Cromwell 1415 Eutaw St.

15 Filed ....., 19.... SEP 22 1921 Registrar

Wchn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1921, to Sept 22, 1921, that I last saw him alive on Sept 21, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of larynx with metastases to glands of neck.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Guy N. Cromwell, M. D.

9/22. 1921 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mansfield La

DATE OF BURIAL Sept 22 1921

20 UNDERTAKER Chas. J. Black ADDRESS 742 W. Northam

Passenger in charge Geo. Whitfield Jack via Penna R.R. Shreveport La

N. B.—Information should be carefully supplied, so that it may be properly entered on the records. All questions should be answered in plain terms, so that it may be understood by persons not familiar with CAUSE OF DEATH. See instructions on back of certificates. SIGNATURE is very important.

Spec. P. & L. T. Co.—1000 Blks.

57141

D/57141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1426 Madison ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda E. Fishack

(a) RESIDENCE. NO. 1426 Madison ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Fishack

6 DATE OF BIRTH (month, day, and year) Sept 24 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER William Horner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mary Ann Kregelo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Miss Dell. Fishack (Address) 1426 Madison ave

15 Filed . 19 SEP 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 16th, 1921, to Sept 21, 1921, that I last saw h[illegible] alive on Sept 21, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No-

What test confirmed diagnosis? Physical Exam

(Signed) H. B. Culbreth M. D.

(Address) 1901 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 23 1921

20 UNDERTAKER Chas G. Black ADDRESS 742 W. North Ave

CAUSE OF DEATH in plain words. [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57142

CERTIFICATE OF DEATH.

REGISTERED NO. 39

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3019 Abell ave. St.: 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Ames Howard

(a) RESIDENCE. No. 3019 Abell Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Gilchrist Howard

6 DATE OF BIRTH (month, day, and year) Sept 28, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED 266

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Shoes

(c) Name of employer Raymond-Swigg-Melloy West Hartfat, Vermont

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Hartford, Vermont

12 MAIDEN NAME OF MOTHER Elmira Ames

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Mrs. F. A. Howard (Address) 2019 Abell Ave City

15 Filed , 19 I. E. Wehn Registrar

P 2 2 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from April , 1921 , to Sept 21 , 1921 , that I last saw him alive on Sept 20, , 1921 , and that death occurred, on the date stated above, at 2 40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Mucus Membrane - Oral Cavity

(duration) 3 yrs. 4 mos. 21 ds.

CONTRIBUTORY (Secondary) General Metastasis (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Apr. 1919

Did an operation precede death? Yes Date of May 1919 Sept 1919

Was there an autopsy? No Microscopic Sections

What test confirmed diagnosis? L. Clarence Cohen

(Signed) , M. D.

, 19 (Address) 2011 Eutaw Place, City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mem Cathedral	Sept 24 19

20 UNDERTAKER McCool & Son E. North Ave ADDRESS

CAUSE OF DEATH.—PHYSICIAN is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57143

CERTIFICATE OF DEATH.

8 D 57143

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Fremont ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Moore

(a) RESIDENCE. NO. 808 N. Fremont ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred all yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
White	Male	Widowed

5a If ~~married~~, widowed, ~~or divorced~~
HUSBAND of (or) ~~Wife~~ Mary B. Moore

6 DATE OF BIRTH (month, day, and year) May 12 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	9	

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work Retired Dairyman

(b) General nature of industry, business, or establishment in which employed (or employer) Milk Business.

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Sarah Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Thomas Moore 808 N. Fremont Ave

15 Filed . 19 Registrar

SEP 22 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21. 1921, to Sept. 21. 1921, that I last saw him alive on Sept 21. 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

four minutes

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. mos. ds.

(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Herbert C. Blake M. D.

Sept 22 1921 (Address) 1014 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Mt Olivet DATE OF BURIAL Sept 23 1921

20 UNDERTAKER Geo W Little ADDRESS 700 Edmondson Ave

Information should be carefully written in plain terms, so that it may be readily understood. CAUSE OF DEATH in plain terms, so that it may be readily understood. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57144

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57144

CERTIFICATE OF DEATH.

151

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 Cornwell ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Still born Baby Kimmitt

(Residence in Baltimore: No. 1525 Cornwell St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word.) Single

6-DATE OF BIRTH. Sept 22, 1921
(Month) (Day) (Year)

7-AGE. ....yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or 10 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE. (State or Country). Balto. md

PARENTS.

10-NAME OF FATHER. John J. Kimmitt

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER Meushaw

13-BIRTHPLACE OF MOTHER (State or Country). Balto. md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Kimmitt

(Address) 1525 Cornwell St

15- Filed ....., 191.... Registrar.

Robert P. Harrison,
Burial Permit Clerk

P 22 1921

important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1921, to Sept 22 1921, that I saw h[illegible] alive on Sept 22 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Lived 10 Minutes
Premature Birth
Still birth Gestation 8½ mos.
(Duration) ....yrs. ....mos. ....ds.
(Cause unknown)

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. E. Burnbarker M. D.

9-22, 1921 (Address) 1531 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral

DATE OF BURIAL. Sept 23, 1921

20-UNDERTAKER Jas. Hayman & Son

ADDRESS 1100 Park

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57145

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57145

37-091

CERTIFICATE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH New City Hospital

CITY OF BALTIMORE: (No. ..... ST.: 11 WARD)

2-FULL NAME Mary Kainoa

(a) RESIDENCE. NO. 303 N Ho Pkwy ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 43				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 637

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hosp Records 9-22-21

15 Filed ..... 19 ..... Registrar

Robert F. Harrison,

EP 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-21-21

17 I HEREBY CERTIFY, That I attended deceased from 8-3 1921, to 9-21-21 1921, that I last saw h alive on 9-21-21 1921, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Syphilitic paraplegia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Clyde McKee, M. D.

(Address) City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Sept 23 1921
20 UNDERTAKER Lilly Ed Zeiler	ADDRESS 403 S. Wolfe

TION is very important. See instructions on back of Certificate.

D 57146 HEALTH DEPARTMENT—CITY OF BALTIMORE

8-091 D 57146

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 233 r Robbelee ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora J. Berry

(Residence in Baltimore: No. 233 r Robbelee St. 2 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	

6-DATE OF BIRTH, ... (Month) ..... (Day) 1919 (Year)

7-AGE. 2 yrs. 1 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... born 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Ernest Berry

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Dora Bond

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Berry

(Address) 233 Robbelee

15- Robert F. Harrison,

Filed ....., 191..... Registrar.

SEP 22 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Jurors, or~~ Jur ~~Inquiry.)~~ find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia 4 D

(Duration) 0 yrs. 5 mos. 4 ds.

CONTRIBUTORY (Secondary) Whooping cough 4 weeks

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Gorsuch M. D. (Coroner.)

9-22, 1921 (Address) 117 N Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Sept 23 1921

20-UNDERTAKER Brandow Eberhard Schumacher — ADDRESS 114 W

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-2414—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Spec.—S 2-14—M. & T.—2000 Blks.

D 57147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57147

CERTIFICATE OF DEATH.

✓ 119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 Wilson Ct. ST.; 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H White

(Residence in Baltimore: No. 535 Wilson Ct St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 30, 1875
(Month) (Day) (Year)

7-AGE, 46 yrs. 4 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Expressman
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Thomas White

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emma White

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha White

(Address) 535 Wilson Ct

15-

Filed Sept. 23, 1921, 191.... Robert P. Harrison, Registrar.

Sept 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept. 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1921, to Sept 22 1921, that I saw h[illegible] alive on Sept 21 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Dr'

Acute Peritonitis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY Endema
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) E. E. Davidson M. D.

Sept 23, 1921 (Address) 1616 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Sept 23, 1921

20-UNDERTAKER Harry L. Dwight — ADDRESS 1364 W Cary

Dead x 64

important. See instructions on back of certificate

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57148

CERTIFICATE OF DEATH.

120 D 57148

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 646 N. Fulton Ave (St.) 16 (WARD)

2-FULL NAME Johanna Weber

(a) RESIDENCE. No. 646 N. Fulton Ave St. WARD.
(If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Johan Weber

6 DATE OF BIRTH (month, day, and year) May 19. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Ernst Bertz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Thon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co

14 Informant Mrs Catherine Lambert
(Address) 646 N. Fulton Ave

15 Filed SEP 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 22, 1921.

That I last saw h alive on Sept 22, 1921.

and that death occurred, on the date stated above, at 11.55 A. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chr Parenchymatous Nephritis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) James Brown M. D.

(Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Sept 24 1921

20 UNDERTAKER: Geo. Weber & Son — ADDRESS: 2303 Edmondson

CAUSE OF DEATH. See instructions on back of certificate. ATTENTION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57149

CERTIFICATE OF DEATH.

15 D 57149

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 S. Bouldin ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorthey Czaya

(Residence in Baltimore: No. 920 S. Bouldin St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Sept 22, 1924
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 4 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER. Walter M. Czaya

11-BIRTHPLACE OF FATHER (State or Country). Balto.

12-MAIDEN NAME OF MOTHER Annie Kluczynski

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter M Czaya

(Address) 920 S Bouldin Ave

15-

Filed ....., 191.... Registrar.

SEP 22 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1924, to Sept 22 1924, that I saw h alive on " " 1924, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

7 Months & Half

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. O'Leary M. D.

Sept 22, 1924. (Address) 1600 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus Cem

DATE OF BURIAL, Sept. 24, 1924

20-UNDERTAKER Stephen J Kraikowski

ADDRESS 1000 S Kenwood Ave

important. See instructions on back of certificate

Spec. 4-1921 M&T 1500 Blks.

D 57150 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

64 D 57150

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1241 McElderry St. (ST.) 5 (WARD)

2-FULL NAME Simon Weisberg

(a) RESIDENCE NO. 1241 McElderry St. (ST.) (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clothing 880

(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Louis Elkin (Address): 1411 E. Baltimore St.

15 Filed SEP 23 1921 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21 1921 to Sept 22 1921.

that I last saw him alive on Sept 22 1921

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

L. Hemiplegia.

2nd attack

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benjamin M Joffe M. D.

9/22, 1921 (Address) 2028 E. Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd DATE OF BURIAL 9/23 1921

20 UNDERTAKER: Jack Louis ADDRESS 1411 E. Baltimore St

CAUSE OF DEATH: See instructions on back of certificate. TION is very important

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57151

CERTIFICATE OF DEATH.

78 D 57151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 306 Penn ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph S. Bruson

(a) RESIDENCE (Usual place of abode) No. 306 Penn St ST., WARD.

Length of residence in city or town where death occurred 51 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Bruson

6 DATE OF BIRTH (month, day, and year): July 12 1869

7 AGE: Years 51 Months 7 mn. Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bottler 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Joseph Bruson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Caroline Stumpf

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Mrs. J. S. Bruson 306 Penn St

15 Filed SEP 23 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1921, to Sept 21, 1921, that I last saw him alive on Sept 20, 1921, and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M A Donnell M. D.

9/22, 1921 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 23 1921

20 UNDERTAKER: John J. Tilden — ADDRESS: 1205 W Lombard

TION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

150728 D 57152

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57152 151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Ader

(a) RESIDENCE NO. 231 President St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank K Ader

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Annie Schatzschneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital Dispensary

15 Filed SEP 23 1921 I. E. Wel... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15th, 1921, to Sept 21st, 1921, that I last saw her alive on Sept 21st, 1921, and that death occurred, on the date stated above, at 12 35 P. m.

The CAUSE OF DEATH* was as follows:

Prematurely

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Weight 3½ lbs.

(Signed) Horace G. Stewart, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Sep. 23 1921
20 UNDERTAKER	ADDRESS
Geo M. Fritz & Son	811 N Wolfe

CAUSE OF DEATH ... on back of certificate. TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57153 ✓

CERTIFICATE OF DEATH.

D 57153

REGISTERED NO. 115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Valley St. ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Radford

(a) RESIDENCE NO. 1121 Valley St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Radford.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
about 70				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Wm. Hillman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland.

14 Informant John T. Radford. (Address) 1121 Valley St.

15 Filed SEP 23 1921 E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1921, to Sept 22, 1921, that I last saw h[illegible] alive on Sept 21, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Intermittent fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. L. Hayward, M. D.

Sept 24 1921 (Address) 2310 Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery. DATE OF BURIAL Sept 24 1921

20 UNDERTAKER Wm. J. Hartwell. ADDRESS 22-36 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that no other cause can be substituted. See instructions on back of certificates. TION is very important.

D 57154

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57154

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 505 Walnut Alley ST.: VV WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Bell

(Residence in Baltimore: No. 505 Walnut alley St.: yrs., 5 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, April 15, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.... none
(b) General nature of industry, business, or establishment in which employed (or employer).... 000

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Eugene Bell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Grace Hall

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Bell

(Address) 505 Walnut alley

15- SEP 23 1921

Filed ....., 191.... J. E. Wohl
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration) ....yrs. 5 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Sept. 23 1921 (Address) 2802 Edgewood ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Sept. 23. 1921
20-UNDERTAKER Katie R. Williams	ADDRESS 1114 W. Saratoga St.

CAUSE OF DEATH in plain terms, so that it may be understood. Omit abbreviations. Be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 57155

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1632 Light St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E. Ballard

(a) RESIDENCE. No. 1632 Light St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 29 ds. How long in U. S., if of foreign birth? 3 yrs. 29 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Percy L. Ballard

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country)

12 MAIDEN NAME OF MOTHER Florence G. Conway

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Percy L. Ballard
(Address) 1632 Light St.

15 Filed SEP 23 1921, 19 Registrar
I. E. Wehn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1921, to Sept 22, 1921, that I last saw him alive on Sept 22, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH was as follows:

Acute Cardiac dilatation

Over

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Shuster, M. D.

9/22/1921 (Address) 1 E Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Sept. 23 1921
20 UNDERTAKER	ADDRESS
I. Fenw McCully	130 E. Fort

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57156 — 40 D 57156

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1474 Stevenson ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F.Cartwright

(a) RESIDENCE. NO. 1474 Stevenson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna P.Cartwright

6 DATE OF BIRTH (month, day, and year) March 4 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	6	16	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Dock Building

(b) General nature of industry, business, or establishment in which employed (or employer) At Sugar Refinery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elizabeth City North Carolina

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Anna P.Cartwright

(Address) 1474 Stevenson St.

15 Filed ..... 19 ..... Registrar

SEP 23 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep't 20 1921

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1921, to Sept. 20, 1921, that I last saw h[illegible] alive on Sept 20, 1921, and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver about 3 mos. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted ——— If not at place of death? .....

Did an operation precede death? yes Date of about May 21.

Was there an autopsy? yes.

What test confirmed diagnosis? .....

(Signed) W. F. Seabury, M. D.

9/24 1921 (Address) 638 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
CEDAR HILL.	SEP 23 1921
20 UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST.

TION is very important. See Instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57157

REGISTERED NO. 108

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. Franklin Square Hospital ST.: WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Von Eiff

(a) RESIDENCE. NO. 1512 Mt. Royal ave. ST.. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 67 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma C. Von Eiff

6 DATE OF BIRTH (month, day, and year) March 17, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

045

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Von Eiff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma C. Voneiff
(Address) 1512 Mount Royal Ave

15 Filed SEP 23 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 19 21. to Sept. 20, 19 21. that I last saw h im alive on Sept. 20, 19 21. and that death occurred, on the date stated above, at 10.40 p. m.

The CAUSE OF DEATH* was as follows:
Suppurative appendicitis.
Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fecal Fistula (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes. Date of Sept. 7. '21.
Was there an autopsy? no
What test confirmed diagnosis? Symptoms.

(Signed) Louis M. Finsko, M. D.
, 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK
DATE OF BURIAL: SEP 23 1921

20 UNDERTAKER: JOHN F. DENNY
ADDRESS: 715 LIGHT ST.

CAUSE OF DEATH. Physician's certificate of cause of death is very important. See instructions on back of certificates.

D 57158

Spec. 6-9-21 M 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57158

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Hanover ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas O. Rose

(a) RESIDENCE. NO. 706 Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 4 mos. 9 ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Rose

6 DATE OF BIRTH (month, day, and year) may 12 1875

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
46	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary

(c) Name of employer Balto

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Robert C. Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Margt Hager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katie Rose

(Address)

15 Filed SEP 23 1921 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept, 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov, 5 1919, to Sept, 20, 1921, that I last saw h[illegible] alive on Sept, 20, 1921, and that death occurred, on the date stated above, at 10 a, m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum - Hospital

(Signed) Wm Francher M. D.

9/22, 1921 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park. Cem.

DATE OF BURIAL Sept 24 1921

20 UNDERTAKER F. A. Francher Son

ADDRESS 539 Hanover

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

D 57159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167

D 57159

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2008 N. Pulaski ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris Virginia Beyer

(Residence in Baltimore: No. 2008 N. Pulaski St., St.: 2 yrs., 10 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	single

6-DATE OF BIRTH, November 10, 1918
(Month) (Day) (Year)

7-AGE, 2 yrs. 10 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none (child).
(b) General nature of industry, business, or establishment in which employed (or employer).....

000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Jesse Beyer

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Enda Pearl

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. Ready

(Address) 2106 Walbrook Ave.

15-

Filed SEP 23 1921, 191.....

Registrar

CAUSE OF DEATH to be plain terms. important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd degree burns of body &

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Playing with matches and clothing caught fire.

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Sept. 21, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Sept 23, 1921

20-UNDERTAKER Martin Fahey & Sons — ADDRESS 827 N. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57160 D 32160

43

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Shields alley ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Sheridan

(a) RESIDENCE. No. 1213 Shields alley ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Md Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Fanny Sheridan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs. Wallace 312 Canton alley

15 Filed SEP 23 1921 19 I. E. Weiner Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20-1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1921, to Sept 20, 1921, that I last saw h alive on Sept 18 1921, and that death occurred, on the date stated above, at 10:20 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile debility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Jas C Carper M. D.

19 (Address) 1063 Myrtle ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 9/23/21

20 UNDERTAKER Samuel Wensley ADDRESS 578 N Eutaw

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 57161

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 753 E. 30th ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie P. Fredrick

(Residence in Baltimore: No. 1642 N. Wash. St. St. 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 23 (Day), 1873 (Year)

7-AGE, 48 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, John W. Stevens

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Virginia Anthony

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Fredrick

(Address) 753 E. 30th St.

15- Robert P. Harrison,

Filed....., 191.....

9 23 1921 Burial Permit Clerk. Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 21 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1921, to Sept 21 1921, that I saw her alive on Sept 20 1921, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hamorrhage

(Duration) yrs. 3 mos. 17 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jacob Fisher M. D.

Sept 22, 1921 (Address) 1823 N. Wash St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Sept 26, 1921

20-UNDERTAKER Wm Carlson ADDRESS 502 E Balto

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 57162

57162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

134

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Lt. Balt. General Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Layn

(a) RESIDENCE. NO. 517 N. Eutaw St. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs mos ds How long in U. S., if of foreign birth? 40 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis R Layn

6 DATE OF BIRTH (month, day, and year) Jan 9 1881

7 AGE Years 40 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Tayla Willey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mari Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Lewis R Layn

(Address) 517 N Eutaw St

15 Filed , 19 SEP 23 1921 Registrar

I. E. Wehr

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1921, to September 22, 1921, that I last saw her alive on September 22, 1921, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Extra Uterine pregnancy (Ruptured)

(duration) yrs. mos. 7 ds.

Hemorrhage + Shock

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 9/22/21.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James Hulett Williams, M. D.

, 19 (Address) Balt. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem't DATE OF BURIAL Sept 26 1921

20 UNDERTAKER J. B. Cook ADDRESS 502 E. North Ave

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57163

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57163

64-091

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH New City Hosp. ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.....

2-FULL NAME Matilda Miller

(a) RESIDENCE. NO. Bay View ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

11 Informant Hosp. Records (Address)

15 Filed SEP 23 1921 I. E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-1921

17 I HEREBY CERTIFY, That I attended deceased from 9-7-21, 1921, to 9-22-, 1921, that I last saw h alive on 9-22, 1921, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde Moncrief M. D.

9-22-1921 (address) New City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept 23 1921

20 UNDERTAKER H. Vanderford Sons

ADDRESS 710 Hull St.

FORM OF CERTIFICATE. See instructions on back of certificates. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57164

CERTIFICATE OF DEATH.

D 57164

REGISTERED NO. 66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 N. Mount ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Isaac Bowser

(a) RESIDENCE. NO. 1515 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hezziah Bowser

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 048

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Mineral Co. W. Va.

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) — (State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Charles E. Bowser. (Address) 1516 Mount St.

15 Filed . 19 I. E. Wohn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1921, to Sept 20, 1921, that I last saw h— alive on Sept 20, 1921, and that death occurred, on the date stated above, at 6.40 P m.

The CAUSE OF DEATH* was as follows: Paralysis ~~Paralysis~~ Uraemia

(duration) — yrs. — mos. 11 ds.

CONTRIBUTORY — (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Jos. Kaelin, M. D.

, 19 (Address) 2008 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Sept 23 1921

20 UNDERTAKER Edward Ruggold ADDRESS 1463 Ca

CAUSE OF DEATH IS PARTICULARLY DESIRED. ATTENDING PHYSICIAN'S ATTENTION IS CALLED TO THE FACT THAT ACCURACY AND COMPLETENESS IN FILLING OUT THIS CERTIFICATE IS VERY IMPORTANT. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage.
No other abnormal
condition.
Not luetic.

State of Virginia,
City of Norfolk, } to-wit:

I, JAMES V. TREHY, Clerk of the Corporation Court of the City of Norfolk, in said State, which said Court is a Court of Record, having a seal, do hereby certify, That U. L. Hudgins whose name is subscribed to the certificate of proof or acknowledgment of the annexed instrument and thereon written, was, at the time of taking such proof or acknowledgment, a Notary Public in and for said City, duly commissioned and sworn, and authorized by the laws of said state to take the acknowledgments and proofs of deeds or conveyances for land, tenements and hereditaments in the said State of Virginia, and to administer oaths; *And further*, that I am well acquainted with the handwriting of said Officer, and verily believe that the signature to said certificate of proof, affidavit or acknowledgment, is genuine. And it is further certified that no seal is necessary to be filed.

In Testimony whereof, I have hereinto set my hand and affixed the seal of said Court, this 22 day of August 1922.

James V. Trehy Clerk.

NOTE:—The City of Norfolk and the County of Norfolk, under the laws of Virginia, are separate and distinct, and the Courts and Officers of one are entirely independent of the other.

AFFIDAVIT.

STATE OF VIRGINIA, CITY OF NORFOLK, SS:

In the matter of the recent death of John J. Bowers, who died on September 20th, 1921, at 1515 Mount Street, Baltimore City, Maryland.

On this 21st day of August, A.D. 1922, personally appeared before me, the subscriber, a Notary Public, in and for the aforesaid City and State, duly authorized to administer oaths, Charles.E Bowers, well known to me to be reputable and entitled to credit, and who, being duly sworn, declares in relation to the aforesaid case as follows;

That he is the son of the said John J. Bowers, deceased; and that he is the informant who gave all such necessary information to the physician who wrote the death certificate of the said John J. Bowers;

That the said physician either misunderstood or failed to write the name correctly, said name being written and appearing on the records of the Health Department of the City of Baltimore, State of Maryland, as John J. Bowser, whereas the correct spelling should be Bowers and should appear so on said records.

Charles E. Bowers ####Seal####

STATE OF VIRGINIA, CITY OF NORFOLK, SS:

Sworn to and subscribed before me this day, and I certify that I read this affidavit to said affiant, and acquainted him with its contents before I executed the same; and said affiant is known to me and he is a credible person.

WITNESS my hand and seal this 21st day of August, A.D. 1922.

V. C. Hodges.
NOTARY PUBLIC.

My Commission expires Oct. 9, 1923.

Wolf

D 57165

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 23 WARD)

REGISTERED No. C 175 001

D 57165

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Wolf

(Residence in Baltimore: No. 1642 S Light St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 1st (Day), 1890 (Year)

7-AGE, 31 yrs. 3 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman D&C
(b) General nature of industry, business, or establishment in which employed (or employer)..... Stone & Webster Co

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Paul R Wolf

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Carrie Gleim

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Wolf

(Address) 2505 N Seltzer St

15- Filed SEP 23 1912, 191.... I. E. Webb Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 21 (Day), 1912 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures (Over) Accident

(Duration) yrs. mos. 1hr

CONTRIBUTORY (Secondary) Shock.

(Duration) yrs. mos. ds.

(Signed) G C Wades M. D.
(Coroner.)

(Address) 143 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, London Park — DATE OF BURIAL, 9—24, 19 12

20-UNDERTAKER, E & H Sloan — ADDRESS 1 E Mt St

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

...—6-9-19—H. P. Co.—1000 Bks.

57166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 57166

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. 727 N. Pattison Park Ave WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary 727 N. Pattison Park Ave Clarke

(a) RESIDENCE. NO. 727 N. Pattison Park Ave WARD.
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.
4 COLOR OR RACE: White.
5 Single, Married, Widowed, or Divorced (write the word): Widow
5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Clarke
6 DATE OF BIRTH (month, day, and year)
7 AGE: Years 56. Months 5. Days 28. If LESS than 1 day, ... hrs. or ... min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland
PARENTS
10 NAME OF FATHER: Conrad Schaffe
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Christina Spurtz
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany Mills
14 Informant (Address): Mary 727 N Pattison Park Ave
Filed SEP 23 1921 E. Wehr Registrar

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1921.
17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1921, to Sept 21, 1921, that I last saw h.. alive on Sept 20, 1921, and that death occurred, on the date stated above, at 2 10 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Intestine
(duration) 1 yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.
18 Where was disease contracted If not at place of death? home
Did an operation precede death? no Date of no
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur O Beaver M. D.
9/23, 1921 (Address) 2600 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer
DATE OF BURIAL: Sept. 24 1921
20 UNDERTAKER: Wendell Leipzel & Son
ADDRESS: 372 W Lombard

Spec.—6-9-19—H. P. Co.—1000 Bks.

57167

HEALTH DEPARTMENT—CITY OF BALTIMORE 57167

CERTIFICATE OF DEATH. X 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1051 Argyle ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Easton

(a) RESIDENCE. NO. 1051 Argyle ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 25 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sydney Easton mch - 1871

6 DATE OF BIRTH (month, day, and year)	Years	Months	Days	If LESS than 1 day. hrs. or min.
7 AGE	30	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Actress 186

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Savannah Ga

PARENTS

10 NAME OF FATHER Dennis Doolan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Savannah Ga

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Memphis Tenn

14 Informant Sydney Easton (Address) 1051 - Argyle W

15 Filed SEP 23 1921 19 L. E. Webb Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 . 1921 . to Sept 22 . 1921 .

that I last saw h[illegible] alive on Sept 22 . 1921 .

and that death occurred, on the date stated above, at 10.15 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Gustav Goldman M. D.

, 19 (Address) 656 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF INTERMENT OR REMOVAL Savannah Ga DATE OF BURIAL Sept 22 1921

20 UNDERTAKER George H. Hollons ADDRESS 1631 W Baltimore St

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 57168

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 57168

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1800 Gough St., 7 WARD)

2-FULL NAME Stanley Klein

(a) RESIDENCE NO. 1800 Gough St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. 2 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 16 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city Md

PARENTS

10 NAME OF FATHER Joseph Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Bettie Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Louis Klein 1800 Gough st

(Address)

15 Filed 9-17-a, 19 SEP 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 16th, 19..., to Sept 22nd 1921.

that I last saw h. alive on Sept 22nd 1921.

and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion from

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Elsner Lab

(Signed) ..... M. D.

, 19 (Address) 607 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 9-23-1921

20 UNDERTAKER Jack Levin, 1411

ADDRESS E. Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 57169

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57169

CERTIFICATE OF DEATH.

REGISTERED NO. 781

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1214 McCulloh St., 5 WARD)

2-FULL NAME Samuel R. McCorkle

(a) RESIDENCE NO. 1214 McCulloh St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah M. Corkle

6 DATE OF BIRTH (month, day, and year) 4/21/1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Robt. McCorkle

11 BIRTHPLACE OF FATHER (city or town) N. C.

(State or country)

12 MAIDEN NAME OF MOTHER Emeline Morris

13 BIRTHPLACE OF MOTHER (city or town) N. C.

(State or country)

14 Informant (Address) Mrs. Sarah M. Corkle 1214 McCulloh St

15 Filed SEP 23 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/21 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1921, to Sept 21, 1921, that I last saw h-- alive on Sept. 21, 1921, and that death occurred, on the date stated above, at 11 9 m.

The CAUSE OF DEATH* was as follows:

I Immediate Exhaustion

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tub.

(duration) about yrs. 5 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins, M. D.

19 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Sept. 24, 1921
20 UNDERTAKER John M. Johnson	ADDRESS 1234 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be classified. TION is very important. See instructions on back of certificates.

Simms.

D 57170

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57170

CERTIFICATE OF DEATH.

165

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 20 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Simms

(Residence in Baltimore: No. 2617 Franklin St

St.; yrs. 12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, June (Month) 3rd (Day), 1884 (Year)

7-AGE, 37 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brass Moulder
(b) General nature of industry, business, or establishment in which employed (or employer): also a Carpenter

9-BIRTHPLACE, (State or Country). England

PARENTS.

10-NAME OF FATHER, James Simm

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER Maria —

13-BIRTHPLACE OF MOTHER (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Simm

(Address) 2617 W. Franklin

15-

Filed ....., 191.... SEP 23 1921

Registrar.

N.B.—A item of information must be given in every case properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept. (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide (Accidental)

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. E. Blades M. D.
(Coroner.)

Sept 22 1921. (Address) 143 E. Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Sept 24, 1921

20-UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57171

109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. New City Hospital, Bay View ST.) 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Dietz

(a) RESIDENCE. No. 3010 Biddle St, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster 145

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Geo. A. Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maggie Lutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records.
(Address) New City Hospital.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1921, to Sept. 20, 1921

that I last saw him alive on September 20, 1921,

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of Sept 20, 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Broadrup. M. D.

9/21/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	SEP 23 1921

20 UNDERTAKER

ADDRESS

Commissioner Health,
per Wm. F. Woodall

Robert F. Hutchison,
Burial Permit Clerk

CAUSE OF DEATH must be given in full. Information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57172

CERTIFICATE OF DEATH.

64 57172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Little Sisters of the Poor (St.) 10 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Murray, (Geigen)

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Gegain

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	90	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Flynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Florence (Address) Preston & Valley Sts

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1921

17 I HEREBY CERTIFY, That I attended deceased from No record ... 19 ... to ... 19 ...

that I last saw h Sr alive on Sept 19 1921.

and that death occurred, on the date stated above, at 1 P.M. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Sept 22 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Hyde Rd	Sept 24 1921
20 UNDERTAKER	ADDRESS
Margaret G Flynn	1422 Light St

CAUSE OF DEATH in plain terms, and return on back of certificates. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57173

CERTIFICATE OF DEATH.

D 57173

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 25 Georgetown Rd ST.; ..... WARD)

2-FULL NAME Bridget Ward

(a) RESIDENCE. NO. Georgetown Rd ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hand Hand

6 DATE OF BIRTH (month, day, and year) Feb. 1826

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	95	1826		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Boyle

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Ireland

14 Informant
(Address)

15 Filed SEP 23 1921, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 22 1921

that I last saw her alive on Sept 21 1921

and that death occurred, on the date stated above, at 1A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. M. Kelly M.D.

Sept 23 1921 (Address) Roland Park Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross Cem A.A.C. DATE OF BURIAL. Sept 24 1921

20 UNDERTAKER Miguel S. Flynn ADDRESS 422 Light

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57174 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57174

CERTIFICATE OF DEATH. REGISTERED NO. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Edmondson ST.) 18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Julius Knoop

(Residence in Baltimore: No. 1017 Edmondson Ave. Ag. 73 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. January 7, (Month) (Day) 1848 (Year)

7-AGE. 73 yrs. 8 mos. 13 ds. If LESS than 1 day, ...hrs. or ....mts.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar-145
(b) General nature of industry, business, or establishment in which employed (or employer): manufacturer

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Ferdinand Knoop

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Sophia Beiger

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Stuart Knoop

(Address) 1017 Edmondson Ave.

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk

P 23192

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. 21, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15th 1919, to Sept. 21 1921, that I saw him alive on Sept. 20 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Heart Block

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(Duration) 4 yrs. ....mos. ....ds.

(Signed) E. A. Kerr M. D.

Sept. 21, 1921 (Address) 172 W Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. 9/24, 1921.

20-UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57175

154

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1112 W. 38th ST. (WARD) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Pickett

(a) RESIDENCE. NO. 1112 W. 38th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Israel Pickett

6 DATE OF BIRTH (month, day, and year) July 30 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jacob Arbaugh

(Address) 1442 W. 38th St

15 Filed Sept 24 1921 Elbert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1921, to Sept 21, 1921, that I last saw h~~er~~ alive on September 21, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

No definite disease, just old age

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Joseph T. Herring, M. D.

. 19 (Address) 1800 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethel Carroll Co	Sept 24 1921

20 UNDERTAKER Chenoweth Son ADDRESS Edmondson Ave

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57176

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57176

CERTIFICATE OF DEATH

REGISTERED NO. 291

1-PLACE OF DEATH New City Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 16 ST.; WARD)

2-FULL NAME Hugh Diamond

(a) RESIDENCE. NO. Bay View ST., WARD. Wilmington Del.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shipbuilder
(b) General nature of industry, business, or establishment in which employed (or employer) 016
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rep. Lords
(Address)

15 Filed 9-23, 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH to be plainly written, and no abbreviations used. See instructions on back of certificate. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-21-1921

17 I HEREBY CERTIFY, That I attended deceased from 8-10-1921, to 9-21-1921, that I last saw him alive on 9-21-1921, and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos. 2w

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Mowell, M. D.

Address New City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilmington. Del	Sept 23 1921
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E. Baltimore St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57177 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57177

CERTIFICATE OF DEATH. 47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1217 E. Biddle St. (10 WARD)

2-FULL NAME Lillie C. Hile

(a) RESIDENCE. NO. 1217 E. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed or divorced (or) WIFE of: Wm. P. Hile

6 DATE OF BIRTH (month, day, and year): 5.23.72.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: 000

9 BIRTHPLACE (city or town) (State or country): Harrisonburg Va.

PARENTS

10 NAME OF FATHER: Adam W. Knicely

11 BIRTHPLACE OF FATHER (city or town) (State or country): Linton Va

12 MAIDEN NAME OF MOTHER: Martha E. Loper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dayton Va.

14 Informant (Address): Mrs Laura Hile 1217 E. Biddle St.

15 Filed Robert P. Harrison, Registrar

P 23 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9. 22. 1921.

17 I HEREBY CERTIFY, That I attended deceased from October 20 19.. to Sept. 22 19 21, that I last saw h.. alive on Sept. 22 19 21 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 11 mos. ds.

Gen'l Carcinoma Ptosis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of Nov. 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wallace H. Mays Jr. M. D.

(Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	9/26 1921

20 UNDERTAKER: Elmer W. Conklin ADDRESS 524 E. Eager St.

CAUSE OF DEATH must be filled in by physician. See reverse side for additional space. Answer every question on back of certificates. TION is very important. See instructions on back.

Spec.—1-10-21—M&T—1500 Bks.

158525 D 57178

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 57178

X74

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene D. Sedgwick.

(a) RESIDENCE NO. 59 Colvin St Rochester New York. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Anna Sedgwick. Name address

6 DATE OF BIRTH (month, day, and year) May 24- 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer.

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER Frederick D. Sedgwick

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York.

12 MAIDEN NAME OF MOTHER May Jane Burrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed ..... 19 ..... Registrar

SEP 23 1921 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7. , 1921 , to Sept. 22 , 1921 , that I last saw him alive on Sept. 22 , 1921 , and that death occurred, on the date stated above, at 9 07 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Uter. (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Olean N.Y.

Did an operation precede death? Yes Date of 9/10/21

Was there an autopsy? Partial (Head)

What test confirmed diagnosis?

(Signed) Jay McKean, M. D.

9-23-21 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rochester N.Y. DATE OF BURIAL Sept. 23 1921

20 UNDERTAKER Wm. C. Black 927 N. Edwards ADDRESS

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57179

D 57179

8-091

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO. 113 E. Montgomery St WARD)

2-FULL NAME Casimil D Rolland

(a) RESIDENCE. NO. 113 E Montgomery st WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 9 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Carol Rolland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Va

12 MAIDEN NAME OF MOTHER Ethel Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilmington N C

14 Informant Carol Rolland

(Address) 113 E Montgomery st

15 Filed ....., 19.... Registrar

Robert T. Harrison

Burial Permit Clerk.

9 23 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/23 1921

17 I HEREBY CERTIFY, That I attended deceased from 9/21, 1921, to 9/23, 1921, that I last saw her alive on 9/23, 1921, and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 20 dy

CONTRIBUTORY (Secondary) Pneumonia (Broncho)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) F. Edw. Smith, M. D.

9/23 1921 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 24 1921
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57180

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1142 Woodyear ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Sidney

(a) RESIDENCE. NO. 1142 Woodyear ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Parker Sidney

6 DATE OF BIRTH (month, day, and year) Dec. 27-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED 270

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Mollie Rogers

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant Isaac Sidney (Address) [redacted] 1713 Pleasant St.

15 Filed ... 19 ... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21— 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1921, to Sept. 21, 1921, that I last saw her alive on Sept. 21, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Chas. T. McCarthy, M. D.

, 19 (Address) 406 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Sept 25 1921

ADDRESS 631 Windsor Ave

20 UNDERTAKER Geo. H. Holland

CAUSE OF DEATH to be plain terms, so that it can be understood. See instructions on back of certificates. TION is very important.

0 2 100

0 1521

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57181

CERTIFICATE OF DEATH.

28

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 109 W. Hamburg ST.; 23 WARD)

2-FULL NAME David A. Wagner

(a) RESIDENCE. No. 109 W. Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 12.19.97.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Rip Yard

(c) Name of employer: Balto. Dry Dock

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Philip Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Ella Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co. Md.

14 Informant (Address): Mrs. Margaret Wagner 109 W. Hamburg St.

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

3 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9.22. 1921

17 I HEREBY CERTIFY, That I attended deceased from November 19 17, to Sept. 22 19 21

that I last saw him alive on Sept. 22 19 21

and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis 4

(duration) yrs. mos. ds.

Pulmonary Hemorrhage

CONTRIBUTORY (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What tests confirmed diagnosis? Clinical

(Signed) Wm. H. A. Meyer, M. D.

9/23, 1921 Address 1031 N. Eutaw Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Sept 26 1921
20 UNDERTAKER	ADDRESS
B. Schlosnagle Son	1539 Lemmon St.

CAUSE OF DEATH. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57182

40

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: NO. Monument & Eighth St ST.: N WARD)

2-FULL NAME Mary Virginia Johnson

(a) RESIDENCE. NO. Eighth & Monument ST., ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. X mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Johnson

6 DATE OF BIRTH (month, day, and year): Dec 25 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	8	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House-wife
(b) General nature of industry, business, or establishment in which employed (or employer): General house-work for husband
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: William McIntosh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Hannah Walter Margaret A. McIntosh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant (Address): Frank Johnson Monument St. & Eighth

15 Filed Sept 23 1921 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 1920 to Sept. 21 1921

that I last saw her alive on Sept. 21 1921

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

Syncope & hemorrhage

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach (duration) 1 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? same as carcinoma

(Signed) Jas. L. Pomax M. D.

Sept. 22 1921 (Address) 248 So 3d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Sept 22 1921

20 UNDERTAKER: Wm J. Pickuerkons

ADDRESS: North & Pa

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—1-10-21 M&T 1500 Bks.

D 57183 HEALTH DEPARTMENT—CITY OF BALTIMORE 42 D 57183

CERTIFICATE OF DEATH.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital St., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Belle Romans

(a) RESIDENCE NO. 516 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Frank Romans

6 DATE OF BIRTH (month, day, and year) Jan 10-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	62	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Augusta Ga

PARENTS

10 NAME OF FATHER Wm Coffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Amanda Bird

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Fannie E Merritt

(Address) 516 Park Ave

15 Robert F. Harrison,

Filed ..., 19 ... Registrar

23 1921 Asst. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1921, to Sept 23, 1921.

that I last saw her alive on Sept 23, 1921,

and that death occurred, on the date stated above, at 6 30 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Leonday Raymond Romans of Colon (duration) 7 yrs. 2 mos. 5 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) J. Thorn Dulany M. D.

, 19 (Address) 1001 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D C

DATE OF BURIAL Sept 26 1921

20 UNDERTAKER Wm J Tuckwell & Sons

ADDRESS Rockville Md

CAUSE OF DEATH in plain terms, so that it may be understood by persons not physicians. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57184

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE, NO. 505 Wilcomeal ST., 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Gross

(a) RESIDENCE. NO. 505 Wilcomeal ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Gross

6 DATE OF BIRTH (month, day, and year) Unknown 1853

7 AGE — Years: 68 — Months: - — Days: . — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ,

14 Informant (Address): Eliza Gross 505 W. Wilcomeal

15 Filed 19 Robert P. Harrison, Registrar

2-2-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/20/21

17 I HEREBY CERTIFY, That I attended deceased from 7/18/21, to 9/20/21, that I last saw h... alive on 9/19/21 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cardio Vascular disease (duration) about yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Lang Bowley, M. D.

9/21/21 (Address) 408 S Shore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION, OR REMOVAL: Dukes Wy Md

DATE OF BURIAL: 9/24/21

20 UNDERTAKER: Wm Gerhold

ADDRESS: 401 W Lanvale St

D 57185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57185

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 214 W. Camden St. ST.: 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Constantine Sviridiuk.

(Residence in Baltimore: No. 214 W. Camden St.

10 ------ St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, Do not know., 1 (Month) (Day) (Year)

7-AGE, 50 yrs. ---------- mos. ---------- ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kasmer Wolusuk.

(Address) 214 W. Camden St.

15- Filed SEP 24 1921 191.....

GG

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 22nd. 1921, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D. (Coroner.)

Sep. 24, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Schwarcz Cem.	Sept 24 1921
20-UNDERTAKER	ADDRESS
John Greblinuckas	425 S. Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Can't [illegible] important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 57186

57186

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1121 Forrest Place St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Kirwin

(a) RESIDENCE. No. 1121 Forrest Place St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of William F. L. Kirwin

6 DATE OF BIRTH (month, day, and year) 8-22-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Maryland

PARENTS

10 NAME OF FATHER John Craddock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Malanthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William F. L. Kirwin (Address) 1121 Forrest Pl.

15 Filed . 19 SEP 24 1921 Registrar

M 7, a.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15 1921 to Sept. 22 1921, that I last saw h e alive on Sept 22 1921, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Both Lungs.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No history

Did an operation precede death? Date of

Was there an autopsy? Clinical Symptoms

What test confirmed diagnosis?

(Signed) Thos. H. Haynes, M. D.

, 19 (Address) 1 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 9 26 1921

20 UNDERTAKER Howard Jenkins & Sons — ADDRESS N. Gilmor & Orchard

CAUSE OF DEATH ... See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57187

D 57187

REGISTERED NO. 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2209 Bel Air Ave. (ST.:) 8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Crist

(a) RESIDENCE. NO. 2209 Bel Air Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 21 '21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none 000
(b) General nature of Industry, business, or establishment in which employed (or employer) premature infant
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm A. Crist
11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.
12 MAIDEN NAME OF MOTHER Irene Dorn
13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Irene Dorn Crist
(Address) 2209 Bel Air Ave.

15 Filed ..., 19 ... Registrar
E. Wehr SEP 24 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1921, to Sept 22, 1921, that I last saw h[illegible] alive on Sept 22, 1921, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:
Premature birth 5th month pregnancy (rupture amniotic Sac.)

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) [illegible], M. D.
9/23 1921 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Sept 24 1921
20 UNDERTAKER Lilly & Geier	ADDRESS 400 S. Wolfe St

SEE instructions on back of certificates. ATTENTION is very important.

D 57188

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57188

CERTIFICATE OF DEATH.

REGISTERED No. C 1197

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1600 Lorman ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. E. Creek

(Residence in Baltimore: No. 1600 Lorman St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	Colored	M.

6-DATE OF BIRTH. July 6, 1877
(Month) (Day) (Year)

7-AGE. 44 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Minister
(b) General nature of industry, business, or establishment in which employed (or employer). (018)

9-BIRTHPLACE. (State or Country). A A Co Md

PARENTS.

10-NAME OF FATHER. Wm H Creek

11-BIRTHPLACE OF FATHER (State or Country). A A Co Md

12-MAIDEN NAME OF MOTHER Christana Hall

13-BIRTHPLACE OF MOTHER (State or Country). A A Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Creek

(Address) 1600 Lorman St

15- Filed SEP 24 1921 I. E. Webb Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Anthracosis

(Duration) yrs. 6 mos. ds.

(Signed) J. T. Kennedy M. D.
(Coroner)

Sept 22 1921 (Address) 2832 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn

DATE OF BURIAL. Sept 23 1921

20-UNDERTAKER Samuel J Kennedy

ADDRESS 4708 Belair

JUN 25 26

N. B. Every item of information must be given in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57189

8125 57189

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Argyle Ave St.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Martin

(Residence in Baltimore: No. 1208 Argyle Ave St.: 78 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE. 78 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. James Martin

(Address) 1208 Argyle Ave

15-

Filed SEP 24 1921, 191.... I. E. Wohl Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 20, 191... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1921, to Sept. 20 1921, that I saw h.. or alive on Sept. 19 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Diffuse Arterio-Sclerosis

Cardiac Dilatation

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. 4 mos. ..... ds.

(Signed) W. S. Carter M. D.

Sept 24 1921 (Address) 1215 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem. DATE OF BURIAL, Sept. 24, 1921.

20-UNDERTAKER Samuel J. Hamby ADDRESS 578 N. Eutaw

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57190

D 57190

CERTIFICATE OF DEATH.

REGISTERED NO. C 131

1-PLACE OF DEATH Hebrew Hospital.

CITY OF BALTIMORE: (NO. ..... ST.; 15 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Fannie Snyderman

(Residence in Baltimore: No. 2009 McKean Ave. St.; 23 yrs., 4 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single.

6-DATE OF BIRTH, May (Month) 2 (Day), 1898 (Year)

7-AGE, 23 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Saleslady 064
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Jacob Snyderman

11-BIRTHPLACE OF FATHER (State or Country), Russian Poland

12-MAIDEN NAME OF MOTHER Rebecca Schwartz

13-BIRTHPLACE OF MOTHER (State or Country), Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Snyderman

(Address) 2009 McKean Ave

15-

SEP 21 1921

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 23 1921, to Sept. 24 1921, that I saw her alive on Sept 24 (2:29am 1921), and that death occurred, on the date stated above, at 2:30 A.m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

36 hours (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dermoid Cyst of ovary (ruptured). 5 wks.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Moses Gellman M. D.

Sept 24, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 1 ds. In the State 23 yrs. 4 mos. 2 1 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL, Hebrew Washington Rd

DATE OF BURIAL, ..., 1921

20-UNDERTAKER Jack Lewis

ADDRESS

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57191

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57191

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 519 Pine St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Miller

(a) RESIDENCE. No. 519 Pine St ST., 17 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stockkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Stock

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thos Miller

(Address) 519 Pine St

15 Filed SEP 26 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1921, to Sept. 23, 1921, that I last saw him alive on Sept 23 1921, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart—
(By Violent Exertion)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Valvulatis of heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John R. Crosley M. D.

, 19 (Address) 723 Gorsuch St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Sept 26 1921

20 UNDERTAKER Samuel Kemsley

ADDRESS 2 Baltimore

CAUSE OF DEATH in plain terms, so that it may be understood by the average person. Omission of any item of information called for by this certificate will delay the issuance of a burial permit. See instructions on back of certificate. TION is very important.

D 57192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57192

CERTIFICATE OF DEATH.

71

REGISTERED NO. C.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 317 E. 21½. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hicks

(Residence in Baltimore: No. 317. E. 21½ st St.; unknown yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colord	Single

6-DATE OF BIRTH. March (Month) 1 (Day) 1920 (Year)

7-AGE. 1 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country). Philadelphia

PARENTS.

10-NAME OF FATHER. William Hicks

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER. Lillian Mosely

13-BIRTHPLACE OF MOTHER (State or Country). S C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) by Gaston William Hicks
(Address) 317 E 21/2 St

15-
Filed SEP 24 1921 191.. I. E. Wehn, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Sept 23 1921 (Signature) J. Thomas Mahoney M. D. (Coroner)
(Address) 1032 Rolandson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Sept 24, 1921
20-UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact residence is very important. See instructions on back of certificate.

Cause unknown

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

D 57193

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57193

CERTIFICATE OF DEATH.

REGISTERED No. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1417 Longwood St.: 8 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.. August Trebert

(Residence in Baltimore: No. 1417 Longwood St.; 57 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH. January 22, 1853 (Month) (Day) (Year)

7-AGE, 68 yrs. 8 mos. 0 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Chair Decorator
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Gustav Trebert

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Johanna Rhode

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Johanna Trebert

(Address) 1417 Longwood St.

15-

Filed SEP 24 1921 19.. I. E. Wehn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Sept 23. 1921 (Address) 2802 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. London Park Cemetery

DATE OF BURIAL. Sept 26th 1921

20-UNDERTAKER. George Schilling & Sons

ADDRESS 1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 57194

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57194

CERTIFICATE OF DEATH.

Registered No. C 71

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1629 Gough St. ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Steven A. Bandrowski

(Residence in Baltimore: No. 1629 Gough St St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, Dec. 13, 1920
(Month) (Day) (Year)

7-AGE, yrs. 9 mos. 9 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Stephen Bandrowski

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. F. Williamson

(Address) 1629 Gough

15- L. E. Wehn SEP 24 1921
Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy from Convulsions

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Tinsley M. D.
(Coroner.)

9/24/21, 191.. (Address) 1500 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents

DATE OF BURIAL, Sept. 24, 1921

20-UNDERTAKER Martin W. E. Supt

ADDRESS 37 S. Am

N. B. Every item must be carefully classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 57195

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57195

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1718 N. Chapel. St. ST. 8 WARD)

2-FULL NAME Frances. M. Buschman

(a) RESIDENCE NO. 1718 N. Chapel. St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ---------- ---

6 DATE OF BIRTH (month, day, and year) May-21-1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adolph. Buschman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary. Athman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mr Adolph Buschman (Address) 1718 N Chapel St

15 Filed SEP 24 1921 I. E. Wohn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept.-22-1921

17 I HEREBY CERTIFY, That I attended deceased from DEC 8 - 1920, 19 , to SEP 22 1921 19 ,

that I last saw he alive on SEP 22 1921 , 19

and that death occurred, on the date stated above, at 4.45 P. M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart about 4 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endo Carditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stethoscope Mitral Murmur

(Signed) and my patient Dr. H. Deuker, M. D.

SEP 23 1921 (Address) 728 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 26 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1301 E Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact location of residence must be given. Name of hospital or institution is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 57196 D 57196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1428

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Municipal Tuberculosis Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Chaney

(a) RESIDENCE. NO. 1406 Argyle Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not recorded

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Holt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) M.T.H.

15 Filed SEP 24 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1921, to Sept. 21, 1921, that I last saw him alive on Sept. 21, 1921, and that death occurred, on the date stated above, at 9.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous adenitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Delaglaeta M. D.

9-22-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND. DATE OF BURIAL SEP 24 1921

20 UNDERTAKER Commissioner Health. ADDRESS

Per. Wm. E. WOODALL.

CAUSE OF DEATH must be plainly written, and no abbreviations or ditto marks used. Item 14 is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57197

REGISTERED NO. 1700 D 57197

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 113 S. First St., Brooklyn ST. 25 WARD)

2-FULL NAME Maria A. Twomey

(a) RESIDENCE. NO. 113 S. First St., Brooklyn ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Androw Twomey

6 DATE OF BIRTH (month, day, and year) Feb 22-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Cornolius Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Andrew J. Twomey
(Address) 113 S. First St. Brooklyn

15 Filed ... 19 ... Registrar

SEP 24 1921

CAUSE OF DEATH in plain ... TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 14th 1921, to Sept 23rd 1921, that I last saw h[illegible] alive on Sept 22nd 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Typical Findings of Illness

(Signed) Hans Meibel M.D.

9-27, 1921 (Address) 324 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 9/26 1921

20 UNDERTAKER Chas F. Fraud & Son ADDRESS 118 W. Mt Royal Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57198

91 D 57198

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 111 N. Poppleton St. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Downs Marling

(a) RESIDENCE. NO. 111 N. Poppleton St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 22nd 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Ernest A. Marling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Martha Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant (Address): Ernest A. Marling 111 N. Poppleton St.

15 Filed SEP 24 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15th, 1921, to Sept 22, 1921,

that I last saw h[illegible] alive on Sept 22, 1921,

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Murray M.D. M. D.

Sept 23 1921 (Address) 510 N. Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Sept 24 1921

20 UNDERTAKER: Roger D Cook

ADDRESS: 1003 E Balt St

CAUSE OF DEATH in plain terms, so that it may be readily understood. Name of disease alone is not sufficient. Whether primary, secondary or contributory, should be stated. Duration of each should be stated. This information is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57199

CERTIFICATE OF DEATH.

D 57199

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 N. Robinson ST., WARD)

2-FULL NAME Marie H. Rittenpusch

(a) RESIDENCE NO. 603 N. Robinson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-16-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Leslie Rittenpusch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Anna Siberer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Leslie Rittenpusch (Address) 603 N. Robinson St

15 Filed SEP 24 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/23 - 19 21

17 I HEREBY CERTIFY, That I attended deceased from 9/16/21, 19 , to 9/23/, 19 21,

that I last saw h[illegible] alive on 9/23/1921

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H. H. Herrman, M. D.

(Address) 2919 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cemetery	9-24 1921
20 UNDERTAKER J. A. Moran	ADDRESS 3066 E. Baltimore

IMPORTANT—Should this certificate be incomplete or incorrect it may be returned for correction. Please write plainly with pen and ink and report at once any change in the information given. Be sure that it may be properly classified. Use only standard abbreviations. Do not report merely symptoms of disease or conditions resulting from disease as CAUSE OF DEATH in plain terms, so that it may be properly classified. Please report all deaths promptly. Fill out all items on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-6-19—H. P. Co.—1000 Bks.

D 57200

HEALTH DEPARTMENT—CITY OF BALTIMORE

63-001

D 57200

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 406 Lauren ST. 14 WARD)

2-FULL NAME Elmer Shorter

(a) RESIDENCE. NO. 406 Lauren ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Infant

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — child
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Oscar Shorter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jennie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Interment (Address) Oscar Shorter

15 Filed 19 Registrar

Robert F. HARRISON,
Burial Permit Clerk.

SEP 25 1921

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept-20 — 1921, to Sept 24 1921, that I last saw him alive on Sept 24 1921, and (that) death occurred, on the date stated above, at 11-45 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonary Congestion
Cardiac failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ac. Gastro enteritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Cannot say -

Did an operation precede death? N Date of -

Was there an autopsy? N

What test confirmed diagnosis? Tuberculin Test

(Signed) Edw Short M. D.

9/24 1921 (Address) 1812 David Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 9/25/21

20 UNDERTAKER Edmund Hawley — ADDRESS 524 N Bdle

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57201

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 708 Little George St.: 17 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Cornelius Dawson Part.

(a) RESIDENCE. No. 708 Little George ST. WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Aug 17-21

7 AGE: Years 1 Months Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wilford Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Irene Crosby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Irene Dawson 708 Little George

15 Filed . 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

SEP 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18th 1921 to Sept 24th 21 that I last saw h alive on Sept 24th 21 and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Coma Diabetic

Gangrene

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis & Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Glycosuria

(Signed) Geo. W. Latimer M.D.

(Address) 525 N Monte Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem

DATE OF BURIAL: Sept 26 1921

20 UNDERTAKER: Samuel Hensley

ADDRESS: Balto

CAUSE OF DEATH in plain terms, so that it may be readily understood. See back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57202

CERTIFICATE OF DEATH.

78 D 57202

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318- E - 23 5 St., ST.: 12 WARD)

2-FULL NAME Julius Singleton.

(a) RESIDENCE. NO. 318- E - 23 St. ST., 12 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Brown	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 10 - 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Anderson S.C.

PARENTS

10 NAME OF FATHER Elias Singleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anderson S.C.

12 MAIDEN NAME OF MOTHER Lucy Singleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anderson. S.C.

14 Informant Elias Singleton
(Address) 318 E 23 St

15 Filed SEP 23 1921, 19 Robert P. Harrison, Registrar
(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept., 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept., 23, 1921, to Sept., 24, 1921, that I last saw him alive on Sept., 24, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum —

(Signed) L. A. Johnson, M. D.

926 1921 (Address) 211 E - 23 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt. Auburn Cem. Sept 27 19

20 UNDERTAKER — ADDRESS

Samuel Saunders, Belair

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57203

D 57203

151

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2501 Oak ST., 12 WARD)

2-FULL NAME Helen Simpson

(a) RESIDENCE NO. 2501 Oak ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 6th yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 16 1921

7 AGE Years 6 Months Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ~ 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Pearl Atkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Henry Simpson (Address) 2501 Oak St

15 Filed ..... , 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk.

SEP 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1921, to Sept 22, 1921, that I last saw h... alive on Sept 22, 1921, 10:30P m. and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Premature birth cause

Premature birth, eclampsia

Epilepsy, Petit mal

Status Epilepticus (duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) P. Carl Schmidt M. D.

(Address) 1534 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Sept 1921

20 UNDERTAKER Samuel Kunkel

ADDRESS 378 N Bradd

IMPORTANT—Write CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57204

CERTIFICATE OF DEATH.

089

91 D 57204

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 930 N Duncan ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Pulbet

(a) RESIDENCE. NO. 930 N Duncan ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Pulbet

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Robt Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Ann Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) John Pulbet 930 N Duncan St

15 Filed Robert P. Harrison, Registrar

9 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-18, 1921, to 9-22, 1921, that I last saw h[illegible] alive on 9-22, 1921 and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows: Acute Bronchitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) [illegible] M. D.

9-22, 1921 (Address) 1000 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Francis Harford Co	Sept 25 1921
20 UNDERTAKER	ADDRESS
Chas Evans & Son	1906 Gorsuch

CAUSE OF DEATH in plain terms. Secondary cause should be stated if it contributed to death. Do not use abbreviations or symbols. Do not state mode of dying, such as heart failure, asthenia, etc., but the disease causing it. Operations should be stated only when performed for some other disease than that which caused death. Violent deaths must be fully explained. Write plainly in ink. Fill all blanks. Use additional sheet if necessary. Information required by law. Prompt and accurate answers are very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57205

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 57205

X 64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Maryland Gen. Hospital ST.; 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick W. Walsh

(a) RESIDENCE. NO. 1412 W. Pratt ST., 19 WARD. (Phillipsburg N. J.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 25 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Walsh

6 DATE OF BIRTH (month, day, and year) About - 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work draftsinspector

(b) General nature of industry, business, or establishment in which employed (or employer) — 086

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) England,

PARENTS

10 NAME OF FATHER Walter Walsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Cecile Walsh (Address) 1412 W. Pratt St

15 Filed SEP 25 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 — 1921.

17

I HEREBY CERTIFY, That I attended deceased from Sept 17th, 19 21, to Sept 24th, 19 21, that I last saw h[illegible] alive on Sept. 24th, 19 21, and that death occurred, on the date stated above, at 5:50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic arterial Hypertension, Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Phillipsburg N. J.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Medical Certificate, M. D.

, 19 (Address) Maryland Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phillipsburg - N. J. DATE OF BURIAL Sept 25 1921

20 UNDERTAKER [illegible] & MOWER COMPANY (WILLIAM F. WOOBER, Successor) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fill in all items. Information required may be given on back of certificates. TION is very important. See instructions on back of certificates.

Form.—6-9-19—B. F. Co.—1000 Blks.

D 57206 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57206

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 237 Myrtle Ave ST. 4 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Howell

(a) RESIDENCE. No. 237 Myrtle Ave ST.

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1873

7 AGE: Years 48 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steamfitter

(b) General nature of industry, business, or establishment in which employed (or employer): 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Leo Lee 237 Myrtle Ave

15 Filed SEP 25 1921 Robert P. Harrison, Registrar

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. Indefinite terms will not be accepted. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 19 1921, to Sept 21 1921, that I last saw h alive on Sept 20 1921, and that death occurred, on the date stated above, at 5 A. m. The CAUSE OF DEATH* was as follows:

Ruptured Appendix Abscess

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. Norwood M. D.

Sept 21 1921 (Address) 489 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery

DATE OF BURIAL: Sept 25

20 UNDERTAKER: P. C. Gross

ADDRESS: 1405 Mordecai

Spec.—1-10-21—M&T—1500 Blks.

Dr. Glantz. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57207 170 D 57207

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3720 Eastern Ave ST., 26 WARD)

2-FULL NAME Justine Muttay

(a) RESIDENCE NO. 3720 Eastern Ave. ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Muttay

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER Otto Will

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Mella B. Rosenbaker
(Address) 3720 Eastern Ave

15 Filed ..... 19 ..... Registrar

25 1021 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1920, to Sept. 23, 1921, that I last saw her alive on Sept. 22, 1921, and that death occurred, on the date stated above, at 5 9, m.

The CAUSE OF DEATH* was as follows:

Chron. Interstitial Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinary

(Signed) J. A. Glantz, M. D.

Sept. 15, 1921 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL Sept 26 1924

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57208

HEALTH DEPARTMENT—CITY OF BALTIMORE

43

D 57208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 722 N. Gilmor (St.) 16 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Winifred Casey

(a) RESIDENCE. No. 722 N. Gilmor (St.) (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? 57 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Nov 20th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic Service

(c) Name of employer: Virginia Crib

9 BIRTHPLACE (city or town) (State or country): Annte Arod Caroline County Maryland

PARENTS

10 NAME OF FATHER: Patrick Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country): County Cork Ireland

12 MAIDEN NAME OF MOTHER: Mary Donahue

13 BIRTHPLACE OF MOTHER (city or town) (State or country): County Cork Ireland

14 Informant (Address): Ellen Strachan 722 N. Gilmor St

15 Filed Robert F. Harrison, Registrar
Burial Permit Clerk.
9 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from August 19th 1920 to Sept 22nd 1921 that I last saw h alive on Sept 22nd 1921 and that death occurred, on the date stated above, at 1.05 a. m.

The CAUSE OF DEATH* was as follows:

Acute Transverse Myelitis

(duration) — yrs. 6 mos. — ds

CONTRIBUTORY (Secondary) Carcinoma of the Cervix

(duration) 1 yrs. 6 mos. — ds

18 Where was disease contracted if not at place of death? 925 N. Gilmor St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological Exam

(Signed) Wm. Bullman M. D.

9/23. 1921 (Address) 1170 N. Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral cemetery

DATE OF BURIAL: 9-26-1921

20 UNDERTAKER: Henry C. Brannings Son

ADDRESS: 17 N. Schroeder Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of fact is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57209

CERTIFICATE OF DEATH.

D 57209

REGISTERED NO. 108

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Maryland General Hospital ST. 28 WARD)

2-FULL NAME Mary Loewer

(a) RESIDENCE. NO. 4405 Maine Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Chas M Loewer

6 DATE OF BIRTH (month, day, and year) August 29, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Daniel Bunge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Delia Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Chas Loewer 4405 Maine Ave

15 Filed 9 25 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that if may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/22 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1921, to Sept 22, 1921, that I last saw h[illegible] alive on Sept 22, 1921, and that death occurred, on the date stated above, at 9.05 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy - Arteriosclerosis.
Bronchopneumonia.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? 4405 Maine Ave Balto Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. P. Coleman, M. D.

(Address) Maryland General Hospital

, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Sept 26 1921

20 UNDERTAKER: Mc Mus John W. Tenfelde Son — ADDRESS: 501 N. Fayette

D 57210

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57210

CERTIFICATE OF DEATH.

182

REGISTERED NO. C

1 PLACE OF DEATH
CITY OF BALTIMORE (No. St Joseph Hospital St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Arthur Hughes.

(Residence in Baltimore: No. 232 n. Bond. St. 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 7 (Day), 1888 (Year)

7-AGE, 33 yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Driver
(b) General nature of Industry, business, or establishment in which employed (or employer) Dr

9-BIRTHPLACE, (State or Country), Wash D.C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Flenie Hughes

(Address) 232 N. Bond St.

15-

Filed Sept 25, 1921 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach perforated shot (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) H. Knox Insley M. D. (Coroner)

Sept 23, 1921 (Address) 4 E. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Washington D.C. DATE OF BURIAL, Sept 26 1921

20-UNDERTAKER Chas. H. Johnson ADDRESS 446 N. Carolina

N. B.—Every item of information should be carefully supplied. Also CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

(Koch)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57211

D 57211

CERTIFICATE OF DEATH.

170

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 S. Luzerne ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Koch

(Residence in Baltimore: No. 743 S. Luzerne Ave ST.; 34 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown, ... (Month) ..... (Day) 1852 (Year)

7-AGE, 69 yrs. 0 mos. 0 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Andrew Kopic

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE ~~IS~~ TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Ferdinand Koch

(Address)..... 943 S Luzerne

15-

Filed....., 191.....
Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 23 (Day), 1911 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 19 1911, to Sept 2 1911, that I saw h er alive on Sept 2 1911, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

1 Chronic Brights

(Duration) ..... yrs. ca. two yrs

CONTRIBUTORY (Secondary) apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank J. Jamison M. D.

Sept 25, 1911 (Address) 2411 East Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Sept 27 1911

UNDERTAKER Wm Packwood & Wesley

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57212 ✓ D 57212

CERTIFICATE OF DEATH.

× 74

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.., 7 WARD)

2-FULL NAME Annie Medley

(a) RESIDENCE NO. ~~New Britain~~ Manchester, Conn. ST., ... WARD 4

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Mr. Ralph Medley Same address

6 DATE OF BIRTH (month, day, and year) May 26. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ...min.
	44	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... —

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Edams Rawnsley.

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Wilson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) England

14 Informant ..... (Address) Johns Hopkins Hospital Nurses

15 Filed ..... 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk.

P 25 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1921

17 I HEREBY CERTIFY, That I attended deceased from 9/21 ....., 1921, to 9/25 ....., 1921, that I last saw her alive on 9/25 ....., 1921, and that death occurred, on the date stated above, at 7:26 a m.

The CAUSE OF DEATH* was as follows:

Brain Tumor.

(duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 9/23/21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

9/25, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Providence R.I.

DATE OF BURIAL 9/26 1921

20 UNDERTAKER Chas F. Evans & Son

ADDRESS 118 W Mt Royal Ave

CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. See instructions on back of certificates.

TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57213

D 57213

CERTIFICATE OF DEATH.

'19

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE. NO. 1501 E. Monument ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Schreiner

(a) RESIDENCE. NO. 1501 E. Monument ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary Schreiner

6 DATE OF BIRTH (month, day, and year) 8. 19. 64.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	1	5	

8 OCCUPATION OF DECEASED 045
(a) Trade, profession or particular kind of work Retired Dry Goods
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer See Balto

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS
10 NAME OF FATHER Fred. Schreiner
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Elizabeth Faust
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Mary Schreiner 1501 E. Monument St.

15 Filed ... 19 ... Registrar

25 1921 Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9. 24. 1921.

17 I HEREBY CERTIFY, That I attended deceased from October 20 1918 to Sept. 24 = 1921
that I last saw him alive on Sept. 24 = 1921,
and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) General Dropsy (duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) Charles H. A. Meyer M. D.
9/25, 1921 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Sept 27th 1921

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E. Monument St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

57214

D 57214

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

53 D 57214

REGISTERED NO. C

(PLACE OF DEATH

CITY OF BALTIMORE (No 108 Loudon Ave. W ST. WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ambrose Bloom

(Residence in Baltimore: No. 108 Loudon Ave. St., 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: April (Month) 23 (Day), 1868 (Year)

7 AGE: 53 yrs. 5 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Latner 040
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Bloom

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rachel Metzger

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Lelia Bloom

(Address) 108 Loudon Ave

15 Filed SEP 26 1921, 191 WPK REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 24 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22, 1921, to Sept 24 1921, that I saw h im alive on Sept 23, 1921, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Leucocythaemia

about 3 yrs. mos. ds (Duration)

Contributory (SECONDARY) Pernicious Anaemia

(Duration) yrs. 1 mos. 18 ds.

(Signed) David M. Stein M. D.

Sept 25, 1921 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Sept. 27, 1921

20 UNDERTAKER: Easton Sons

ADDRESS: Eldcot & City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spmc.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57215

CERTIFICATE OF DEATH.

REGISTERED NO. C

D 57215

1-PLACE OF DEATH
CITY OF BALTIMORE. (No. 1622 E. Madison ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Buena Meyers

(Residence in Baltimore: No. 1622 E Madison St.; 3 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1884 (Year)

7-AGE, 26 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), D. C.

PARENTS.

10-NAME OF FATHER, John Fisher

11-BIRTHPLACE OF FATHER (State or Country), D. C.

12-MAIDEN NAME OF MOTHER Mary —

13-BIRTHPLACE OF MOTHER (State or Country), D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Floyd Meyers

(Address) 1622 E. Madison

15-

Filed SEP 26 1921, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 25, 1917. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept-20 1917 to Sept-25 1917, that I saw h[illegible] alive on Sept-25 1917, and that death occurred, on the date stated above, at 8P m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis Caused by Puerperal Septic Infection Induced

(Duration) .....yrs. .....mos. 4 da.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....da.

(Signed) W. T. Coleman M. D.

Sept-26 1917 (Address) 939 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem.

DATE OF BURIAL, Sept. 26, 1917.

20-UNDERTAKER Chas J. E. Locks

ADDRESS 302 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D 57216

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

29 D 57216

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 S. Bond St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Patrick McFaul

(Residence in Baltimore: No. 822 S Bond St.; yrs. 6 mos. ds.)

Residence in Baltimore city 30 years

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH August 1st (Month) (Day), 1885 (Year)

7-AGE 36 yrs. 1 mos. 21 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Foreman at 086
(b) General nature of industry, business, or establishment in which employed (or employer): boiler Making

9-BIRTHPLACE (State or country) Richmond Va U-SA

PARENTS

10 NAME OF FATHER Martin Joseph McFaul

11-BIRTHPLACE OF FATHER (State or country) Richmond Va U-SA

12-MAIDEN NAME OF MOTHER Alice Martin

13-BIRTHPLACE OF MOTHER (State or country) Virginia U-SA

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary McFaul

(Address) 822 S Bond St

15- Filed SEP 26 1921 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH September 22 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1921, to Sept. 22 1921, that I saw him alive on Sept. 22 1921, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) unknown yrs. mos. ds.

acute dilatation of heart.

Contributory (SECONDARY)

(Duration) unknown yrs. mos. ds.

(Signed) Samuel Silverstein M. D.

Sept 22 1921 [Address] 22 S. Broadway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Oak Lawn Cem — DATE OF BURIAL Sept 26 1921

20-UNDERTAKER H. Sander Sons — ADDRESS 1710 Eat St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Boullow

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 57217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57217

CERTIFICATE OF DEATH.

K 45

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. A. Boullon

(a) RESIDENCE. NO. Fairmont W Va ST., WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 21 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious (Priest)

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER James C. Boullon

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Victoria Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant (Address) Mercy Hospital

15 Filed SEP 26 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25th 21

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to Sept 25, 1921, that I last saw him alive on Sept 25, 1921, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows: Prostatic carcinoma

CONTRIBUTORY (Secondary) Senile Carcinoma (duration) 6 mos. (?) ds.

Prostatic Surgery (duration) 1 yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Dec. 1919

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. F. Brown, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmont W Va

DATE OF BURIAL 9/26/21

20 UNDERTAKER Joseph Fahey Sutton & Co

ADDRESS Fayette

mation should be carefully supplied. Avoid abbreviations. Write plainly. This certificate may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

57218

HEALTH DEPARTMENT—CITY OF BALTIMORE

1091

104 D 57218

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2810 Parkwood Ave St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kenneth Allender

(Residence in Baltimore: No. 2810 Parkwood Ave St.; yrs. 1½ mos. ds.) (all lifetime)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	

6-DATE OF BIRTH, August 2, 1921
(Month) (Day) (Year)

7-AGE, yrs. 1 mos. 28 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, J. P. Allender

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Cora E. Fike

13-BIRTHPLACE OF MOTHER (State or Country), W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. F. Slemmer

(Address) 3226 Madison Ave.

15-

Filed ....., 191.....

Registrar.

SEP 28 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 22 1921, to Sept. 25 1921, that I saw him alive on Sept. 25 1921, and that death occurred, on the date stated above, at 1:50 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Enteritis

(Duration) yrs. mos. 4 ds.

(Signed) J. F. Slemmer M. D.

Sept. 25, 1921. (Address) 3226 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Druid Hill Md.	Sept. 26 1921.
20-UNDERTAKER	ADDRESS
Wm. J. Buckler & Son	North & Pac.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 57219 (PLACE OF DEATH)

804 57219 REGISTERED NO. C

CITY OF BALTIMORE (No. 1834 Linden Ave St. 14 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Houston (Houston)

(Residence in Baltimore: No. 1834 Linden ave St. 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widowed

6-DATE OF BIRTH: April (Month), (Day), 1851 (Year)

7-AGE: 70 yrs. 5 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Phila. Pa.

PARENTS

10-NAME OF FATHER: Edward A. Hutton

11-BIRTHPLACE OF FATHER (State or country): Phila Pa.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Phila. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Houston

(Address) 3534 Reisterstown Road

15- FILED SEP 26 1921 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept (Month) 23 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec, 1920, to Sept 23 1921, that I saw h[illegible] alive on Sept 23, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. 9 mos. ds

Contributory (SECONDARY) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

(Signed) Saunders McClung M. D.

Sept 24 1921 (Address) 1609 Linden ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Arlington Fort Meyers Va. DATE OF BURIAL: Sept 27, 1921

20 UNDERTAKER: John C. Mitchell ADDRESS 120 W. Fayette St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form 6-9-19—H. P. Co.—1000 Blks.

D57220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D57220

CERTIFICATE OF DEATH.

REGISTERED NO. 78

1-PLACE OF DEATH University Hospital
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. Lombard & Greene ST.; 19 WARD)

2-FULL NAME Elsie Bletcher.

(a) RESIDENCE. No. 3441 Chesnut Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 8 mos. 12 ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 13. 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16 years	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seamstress 069
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mrs John Shepherd Baltimore Md.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS
10 NAME OF FATHER John Henry Bletcher
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore
12 MAIDEN NAME OF MOTHER Elsie Masimer
13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Freedom, Penn.

14 Informant Mrs N. Collison
(Address) 3605 Cedar Ave

15 Filed SEP 26 1921 RPK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25- 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-7 , 1921, to 9-25- , 1921, that I last saw her alive on 9 — 25- , 1921, and that death occurred, on the date stated above, at 6:20 p m.

The CAUSE OF DEATH* was as follows:
Acute endocarditis
Ulc

(duration) yrs. mos. ds.
CONTRIBUTORY Streptococcic septi-
(Secondary) Caemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) R. J. Pleyler M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	Sept 26 19 21

20 UNDERTAKER A. L. Marshall ADDRESS 3539 Falls Rd

mation should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Source of infection unknown
Duration Pericarditis
+ septicaemia unknown.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~D~~ 57221

34 D 57221

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Harris

(a) RESIDENCE. NO. 416 W Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
F.	Black.	single

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl ~~Dau~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City.
(State or country)

PARENTS

10 NAME OF FATHER Benj Harris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ella Ball

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant David Earlow
(Address) 216 Pa ave

15 Filed SEP 26 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1921, to Sept 24, 1921, that I last saw h.. alive on Sept. 24, 1921, and that death occurred, on the date stated above, at 1.10 a.m.

The CAUSE OF DEATH* was as follows:

Cervical atresia from admitis

OVER

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Suppuration Meningitis. 12 hrs

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of Sept. 17

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy.

(Signed) F. C. Mann, M. D.

, 19 (Address) St. Joseph Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem

DATE OF BURIAL Sept 27 1921

20 UNDERTAKER Daniel Earlow

ADDRESS 916 Penna ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tuberculous abscess of neck

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57222

CERTIFICATE OF DEATH.

D 57222

REGISTERED No. C 161

1-PLACE OF DEATH

CITY OF BALTIMORE (No. New City Hospital, Bay View WARD 14)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucetta Ware.

(Residence in Baltimore: No. 709 Mosher Street. City. St. 8 yrs., mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Black	Married

6-DATE OF BIRTH, ----- (Month) ..... (Day), 1900 (Year)

7-AGE, 21 yrs. - mos. - ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), North Carolina.

PARENTS.

10-NAME OF FATHER, E. Thomas

11-BIRTHPLACE OF FATHER (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records.

(Address) New City Hospital.

15- Filed SEP 26 1921, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Strychnine

known addict

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Edwin Davis (C. M. D.)
(Coroner)

Sept 23 1921 (Address) 709 Mosher

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL North Carolina

DATE OF BURIAL, Sept 26 1921

20-UNDERTAKER David Earley

ADDRESS 956 Penna Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57223

CERTIFICATE OF DEATH.

45

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD 21)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Eisenman.

(a) RESIDENCE. NO. 1158 Carroll ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs Mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Eisenman.

6 DATE OF BIRTH (month, day, and year) Oct. 14. 1860.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60.	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant; 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John George Eisenmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Julia Street

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs E. Eisenman (Address) 658 Carroll St

15 Filed SEP 26 1921, 19 Registrar RMK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22. 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17. 1921, to Sept. 22. 1921, that I last saw h[illegible] alive on Sept. 21. 1921, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma Left Femur. (Opr)
Metastasis to Left Thigh and Femur.

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pathological Fracture Left Femur. (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 1158 Carroll St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John W Metcalf, M. D.

, 19 (Address) Maryland General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 26" 1921
20 UNDERTAKER	ADDRESS
Geo Leinbach & Son	647 W. Pratt St

mation should be carefully supplied. All entries may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

30 ✓ D 57224

D 57224

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 63 Taylor ST.) 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and add out No. 18.)

2-FULL NAME Wm A Miller Jr

(Residence in Baltimore: No. 63 Taylor St.; ... yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M | 4-COLOR OR RACE. White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, Oct 14, 1917 (Month) (Day) (Year)

7-AGE, 3 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work ..... none (b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Wm A Miller

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Ida Peters

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm A Miller

(Address) 63 Taylor St

15- Filed SEP 26 1921 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 25, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 16 1921, to Sept 25 1921, that I saw h[illegible] alive on " " 1921, and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows: Tuberculosis meningitis

Tuberculosis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulm disease

(Duration) 1 yrs. 1 mos. ... ds.

(Signed) C A Harris M. D.

9-26-21, 1921. (Address) 1600 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept 29 1921

20-UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation very important. See instructions on back of certificate.

D 57225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57225

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1604 E. Monument ST. WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack. Byrd.

(Residence in Baltimore: No. 1604 E. monument St.: yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Col.	Sing

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 26 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Steam 040
(b) General nature of industry, business, or establisbment in which employed (or employer): Laborer

9-BIRTHPLACE, (State or Country). Bor. in Baltimore 6 Years Res. Dudley Va

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

12-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pearl Blake

(Address) 611 Eden St

15- Filed SEP 26 1921 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 21, 1921
..... (Month) ..... (Day) ..... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Injury (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Cyanide of Potassium

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Leslie Pinder M. D.
(Coroner.)

9-21, 1921 (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem — DATE OF BURIAL, Sept 26 1921

20-UNDERTAKER Mrs Ida Jones — ADDRESS 1725 Pennsylvania Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Muth

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57226

CERTIFICATE OF DEATH.

64

D 57226

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST. 1 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Muth

(Residence in Baltimore: No. 116 S. Fremont St. St.: 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dont Know, ... (Month) ..... (Day) 1 (Year)

7-AGE, 70 about yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 640

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country) Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ana Muth

(Address) 116 S Fremont St

15-

Filed SEP 26 1927 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 24 (Day), 1927 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ..... ~~Coroner, as~~ ..... find that said deceased came to ~~his~~ death ~~from the cause~~ (~~Coroner's~~ inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

a fortnight (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

..... (Duration) ..... yrs. Dont Know mos. ..... ds.

(Signed) W. K. Gorman M. D. (Coroner.)

9. 24., 1927. (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Peters	8-27-1927
20-UNDERTAKER H C Browning Son	ADDRESS 517 N. Schroeder St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57227

CERTIFICATE OF DEATH.

45

D 57227

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1548 Gorsuch Ave 9 WARD)

2-FULL NAME George Pauly

(a) RESIDENCE No. 1548 Gorsuch Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Anna Pauly

6 DATE OF BIRTH (month, day, and year): Aug 2 1860

7 AGE: Years 61 Months 1 Days 0 If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paper Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Pauly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna Pauly (Address) 1548 Gorsuch Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1924

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1921, to Sept 2, 1921.

that I last saw him alive on Sept 2 1921

and that death occurred, on the date stated above, at 9.30 a m

The CAUSE OF DEATH* was as follows:

Primary Squamous cell carcinoma neck (Pathological)

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Pathological slide Stain

(Signed) Thomas Speicher M. D.

Sept 26, 1921 (Address) Locust 1419 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet DATE OF BURIAL: Sept 28 1924

20 UNDERTAKER: Wm Carl ADDRESS: 502 E North Ave

Dr Locke 316 North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

57228

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57228

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 Penn St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Dubbey

(a) RESIDENCE NO. 205 Penn ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Blanche A Dubbey

6 DATE OF BIRTH (month, day, and year): July 1 1864

7 AGE: Years 57 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer: American Rail Road Assn

9 BIRTHPLACE (city or town) (State or country): Elliott City Md

PARENTS

10 NAME OF FATHER: Thomas Dubbey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Emitsburg Md

12 MAIDEN NAME OF MOTHER: Katie Harden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Husband's

14 Informant (Address): Blanche A Dubbey 205 Penn St

15 Filed SEP 26 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921 to Sept 25, 1921.

that I last saw him alive on Sept 24, 1921.

and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Guild M. D.

9/26, 1921 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemt

DATE OF BURIAL: Sept 27 1921

20 UNDERTAKER: William Cook

ADDRESS: 526 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must be careful CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

Heiland

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57229

D 57229

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2695½ Fulton ave ST., 70 WARD)

2-FULL NAME Edward C Heiland

(a) RESIDENCE NO. 2695½ Fulton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Selma Heiland

6 DATE OF BIRTH (month, day, and year) Aug 20 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	26	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Carl Hiteland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Henrietta Berry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Selma Heiland
(Address) 2695½ Fulton ave

15 Filed SEP 26 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1921

17 I HEREBY CERTIFY, That I attended deceased from September 1, 1921, to September 23 1921, that I last saw h~~im~~ alive on Sept 23, 1921, and that death occurred, on the date stated above, at 4.50 P m.

The CAUSE OF DEATH* was as follows:

Paraenchymatous Nephritis
Endocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Robert C Hitch, M. D.

Sept 23, 1921 (Address) 2151 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Sept 26 1921

20 UNDERTAKER Wm Cook & Nabb — ADDRESS .....

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57230

CERTIFICATE OF DEATH.

169 D 57230

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Hospital Surgeon ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. O'Brien

(Residence in Baltimore: No. 1705 Baltimore St.: yrs., 41 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. April 4th, (Month) (Day) 1880 (Year)

7-AGE, 41 yrs. 0 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Deckhand
(b) General nature of industry, business, or establishment in which employed (or employer): Oil Co

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Peter J. O'Brien

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Virginia Harrigan

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret O'Brien

(Address) 1705 E Baltimore

15- Filed M.G.A. SEP 26 1921, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 24, (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning by falling from pier

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Chas. Grant Mosher M. D. (Coroner.)

9/25/21 191... (Address) Foot of Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery

DATE OF BURIAL, 9-27, 1921

20-UNDERTAKER E & B Hartle

ADDRESS 115 E Wells

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Fowler

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57231 ✓ D 57231

CERTIFICATE OF DEATH.

79

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1319 n Caroline St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Fowler

(Residence in Baltimore: No. 1319 n Caroline St. yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May 12, 1846 (Month) (Day) (Year)

7-AGE. 75 yrs. 4 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, James Houston

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Helen Crothers

13-BIRTHPLACE OF MOTHER (State or Country) Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. G. L. Crosby

(Address) 4008 Belleone

15- Filed M.T.A., 191.. SEP 26 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. 24, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Apoplexy Hemorrhage .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....

(Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Sept 27, 191.. (Address) ..... 4 Cora

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Sept. 27 1921

20-UNDERTAKER Wm. E. Black ADDRESS 927 W. Edwin

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Lamartina) ✓

D 57232

HEALTH DEPARTMENT—CITY OF BALTIMORE

8-091

D 57232

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 Otterbein — ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvatore Lamatantina

(a) RESIDENCE. No. 515 Otterbein ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Sing G

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 14

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Vincent Lamantina

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Lena Garbo

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Vincent Lamantina
(Address) 515 Otterbein st

15 Filed SEP 26 1921 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1921, to Sept 25, 1921, that I last saw h[im] alive on Sept 25, 1921, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Pertussis

3 wks! (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Ginsburg, M. D.

Sept 26, 1921 (Address) 1221 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethesda Cemetery

DATE OF BURIAL: Sept 26 1921

20 UNDERTAKER: W. M. Routson

ADDRESS: 230 N. Green

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 57233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

63 D 57233

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 S Smallwood ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Hoffmeister

(a) RESIDENCE. NO. 611 S Smallwood ST.: 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	—

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 8 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles W. Hoffmeister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary C. Echeyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Charles W. Hoffmeister
(Address) 611 S. Smallwood St

15 Filed SEP 26 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 18th 1921 to Sept 25 1921, that I last saw him alive on Sept 25 1921, and that death occurred, on the date stated above, at 2 20 p.m.

The CAUSE OF DEATH* was as follows:

Acute Polio myelitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Emma. M. Chung, M. D

, 19 (Address) 400 N Parson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept. 26 1921
20 UNDERTAKER	ADDRESS
Geo. L. Schwab & Bro	201 Park Ave

Should be stated EXACTLY. THE CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57234

CERTIFICATE OF DEATH.

79 D 57234

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 West Lanvale St., ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Harrison Fischer

(a) RESIDENCE. No. 215 West Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1839

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER F. Martin Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER A. Margaretta Fischer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Eleanor Scherer

(Address) 215 West Lanvale St.

15 Filed SEP 26 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1921, to Sept 22, 1921, that I last saw him alive on Sept 22, 1921, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Arteriosclerosis (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Death

(Signed) Stanley Malkemus, M. D.

19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	9/26/21 19

20 UNDERTAKER Henry W. Mears & Son ADDRESS 805 N. Calve

mation should be carefully supplied. AGE should be s
CAUSE OF DEATH in plain terms, so that it may be pro
TION is very important. See instructions on back of cert

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 57235

D 57235

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 1116 S Caroline ST. 21 WARD)

2-FULL NAME Joseph A Kessling

(a) RESIDENCE. NO. 1116 S. Caroline ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Miller

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 53. Months Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frank Kessling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Jos A Kessling 1116 S Caroline St

15 Filed SEP 26 1921 19 I. E. Wehn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 25 1921 that I last saw him alive on Sept 23 1921 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy (immediate)

(duration) yrs. mon. ds.

Arterio Sclerosis.

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? — No —

What test confirmed diagnosis? Clinical

(Signed) H 6 Shillinger M. D.

1921 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine

DATE OF BURIAL: Sept 28 1921

20 UNDERTAKER: [illegible]

ADDRESS: 1200 W Lombard

mation should be carefully supplied. All should be stated EXACTLY. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57236

CERTIFICATE OF DEATH.

X 104 D 57236

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 640 Indiana St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edw. Thomas Rudy

(Residence in Baltimore: No. 640 Indiana Ave St.; .....yrs., ...mos. .....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 23 (Day) 1921 (Year)

7-AGE, ...yrs. 3 mos. 2 da.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Edwt Rudy

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER A. G. Cumbers

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwt Rudy

(Address) 640 Indiana Ave

15- SEP 26 1921

Filed....., 191.... I. E. Webb

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept (Month) 26 (Day) 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 25 1921, that I saw him alive on Sept 24 1921, and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Colitis Ulcerosa

(Duration) .....yrs. mos. 30 da.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....da.

(Signed) John G. Schwerenberg M. D.

Sept 26 1921 (Address) 1120 W. Cross St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....da. In the State .....yrs. .....mos. .....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Richmond Va

DATE OF BURIAL, Sept 28, 1921

20-UNDERTAKER John Toledo

ADDRESS 1200 N Fremont

N. B.—Every blank must be filled with the word or words required, or with the word "None" or "Unknown," as the case may be. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 57237 | H 5 | D 57237

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 N. Mount ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis E. Smoot

(a) RESIDENCE. No. 16 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Smoot

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper 086

(b) General nature of indostry, business, or establishment in which employed (or employer) Machine shop

(c) Name of employer Bartlett -Hayward Baltimore

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Hiram Smoot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Potee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hiram H. Smoot (Address) 912 Columbia Ave.

15 Filed SEP 26 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from June 8th, 1921, to Sep. 23d, 1921, that I last saw him alive on Sep 23d, 1921, and that death occurred, on the date stated above, at 8309 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of throat

about 1½ (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Asphyxia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Undefinite

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopical examination of tissue

(Signed) Benj. Baden M. D.

, 19 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery.

DATE OF BURIAL: Sept 28 1921

20 UNDERTAKER: Joseph B Cook

ADDRESS: 1003 N. Bath St.

mation should be carefully supplied. AGE should be stated EXACTLY. Information as to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 57238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57238

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division Street ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William H. Piper

(a) RESIDENCE. No. Greenville, Tenn ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos 13 ds. How long in U. S., if of foreign birth? yrs mos 1 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. W. H. Piper

6 DATE OF BIRTH (month, day, and year) April 26 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer 047

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Knoxville, Tenn

PARENTS

10 NAME OF FATHER A. M. Piper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va—

12 MAIDEN NAME OF MOTHER Martha Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn.

14 Informant Mrs. Piper (Address) Greenville Tenn.

15 Filed SEP 26 1921, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1921, to Sept 26, 1921, that I last saw him alive on Sept 26, 1921, and that death occurred, on the date stated above, at 8.41 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Large Intestine (Transverse Colon)

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Greenville, Tenn

Did an operation precede death? Yes Date of Sept 9, 1921

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) George S. W. Hardy, M. D.

9/26, 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenville Tenn.	Sept 26 1921

20 UNDERTAKER Jos B. Cook ADDRESS 1103 N Galtos

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57239

D 57239

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Hospital ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LeFarrest LeRoy Whitten

(a) RESIDENCE. NO. Institution Hospital ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter & Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer) 056

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Orrin Whitten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Cotton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Anderson
(Address) Lindenwood Heights

15 Filed SEP 26 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 13 1921 to Sept 23 1921 that I last saw him alive on Sept 23 1921, and that death occurred, on the date stated above, at 11:33 p m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) Joseph Pokorny M. D.

, 19 (Address) South Balto Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	9/26/ 1921
20 UNDERTAKER	ADDRESS
John J. Doherty & Sons	1118 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57240 ✓ D 57240

142-091

CERTIFICATE OF DEATH.

D 57240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View No. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Smith

(a) RESIDENCE. NO. 4711 Fait Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 870

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Benjamin Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Hospital Records, New City Hospital.

15 Filed , 19 . L. E. Webb Registrar

SEP 28 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 21, 19 21, to Sept 24, 19 21, that I last saw h er alive on September 24, 19 21, and that death occurred, on the date stated above, at 8:00 P. M.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Gangrene Left Leg

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) E. E. Broadrup. , M. D.

9/26/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ms. Carmel — DATE OF BURIAL: Sept. 27 1921

20 UNDERTAKER: Jos. J. Herr — ADDRESS: 156 N. Luzerne ave.

mation should be carefully supplied. AGE should be s
CAUSE OF DEATH in plain terms, so that it may be pr
TION is very important. See instructions on back of cert
be stated EXACTLY. PHYSICIANS should
e properly classified. Exact statement of
f certificates.

D 57241 HEALTH DEPARTMENT--CITY OF BALTIMORE D 57241

CERTIFICATE OF DEATH

64

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1024 Buntwood Ave ST. 10 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Honora Marie Murnane

(Residence in Baltimore: No. 1024 Buntwood Ave St.; 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Aug 5th (Month) (Day), 1867 (Year)

7-AGE: 55 yrs. 1 mos. 20 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Honor 037
(b) General nature of industry, business, or establishment in which employed (or employer): wife

9-BIRTHPLACE (State or country): Ireland

PARENTS

10-NAME OF FATHER: Daniel Enright

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Alice Connor

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Murnane

(Address) 1024 Buntwood Ave

15- Robert P. Harrison,

Filed ....., 191 ..... REGISTRAR

Burial Permit Clerk.

SEP 26 1921

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept 25th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16th, 1921, to Sept 25th 1921, that I saw h[er] alive on Sept 25th, 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1 1 yrs. mos. 7 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Augustine O'Connor M. D.

Sept 26, 1921 (Address) 40 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Sept 28 1921

20-UNDERTAKER: H. C. Kindsvatter

ADDRESS: 914 Gramm-Bre

D 57242 HEALTH DEPARTMENT---CITY OF BALTIMORE D 57242

CERTIFICATE OF DEATH

64

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2019 St. Paul ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Caroline Birckhead

(Residence in Baltimore: No. 2019 St. Paul St ; St.; 12 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: October (Month) 18 (Day), 1843 (Year)

7-AGE: 77 yrs. 11 mos. 7 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE (State or country): Lowell, Ohio

PARENTS

10-NAME OF FATHER: Gottlieb Duty

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Caroline Young

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Jean Dinahue

(Address) 2041 E. 73rd St. Cleveland Ohio

15- SEP 26 1921 I. E. Wahn

Filed ....., 191 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept. (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20, 1921, to, Sept 25 1921, that I saw h.. alive on Sept 25 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Right sided hemiplegia

..... (Duration) ..... yrs ..... mos. 2 ds.

Contributory (SECONDARY) Arteriosclerosis

..... (Duration) 5 yrs ..... mos. ..... ds.

(Signed), Geo. L. Buechelle M. D.

Sept. 25 1921 [Address] 210 St. Paul St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: McConnellsville-Ohio

DATE OF BURIAL: Sept 26 1921

20-UNDERTAKER: STEWART & MOWER COMPANY (WILLIAM F. WOODER, Secretary)

ADDRESS: 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57243

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 923 N. Durham St.: 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Svehla

(a) RESIDENCE. No. 923 N. Durham St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Svehla

6 DATE OF BIRTH (month, day, and year) — 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Phelps

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Josephine Brony

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mrs. Svehla (Address) 923 N. Durham St.

15 Filed SEP 26 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2- 1921, to Sept 25 1921, that I last saw h[illegible] alive on Sept 25 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Palpitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Findings

What test confirmed diagnosis?

(Signed) W. J. Hargrove M. D.

Sept 25 1921 (Address) 805 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 28 1921
20 UNDERTAKER	ADDRESS
Frank Erwin Son	1906 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57244

CERTIFICATE OF DEATH.

64 D 57244

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 930 Streeper ST. 1 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Lenz

(Residence in Baltimore: No. 930 Streeper St. St. 30 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April 9, 1867
(Month) (Day) (Year)

7-AGE, 54 yrs. 5 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Lidwig

(Address) 930 S. Streeper St

15-

Filed ....., 191....

Robert P. Harrison,
Burial Permit Clerk.

Registrar.

SEP 23 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Theresa Yeo M. D.
(Coroner.)

Sept 21, 1921 (Address) 1204 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn DATE OF BURIAL, Sept 23, 1921

20-UNDERTAKER Weeb & Hoen ADDRESS 502 E. Monument

Sept 23 1921

D 57245

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57245

CERTIFICATE OF DEATH.

175-001

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.) Franklin Square Hospital ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sylvan Lehman

(Residence in Baltimore: No. 2103 W Saratoga St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, April (Month) 24 (Day), 1846 (Year)

7-AGE, 16 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Nathan Lehman

11-BIRTHPLACE OF FATHER (State or Country), Balto city

12-MAIDEN NAME OF MOTHER Rosa Freid

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nathan Lehman

(Address) 2103 W Saratoga St

15-

Filed....., 191..... Registrar.

Robert F. Harrison
Burial Permit Clerk

261921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage + shock due to
having his leg crushed in
an Auto truck accident

(Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) James M. Kemler M. D.
(Coroner.)

Sept. 26, 1921. (Address) 700 E Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? American Ice Co. Franklin & Payson

Former or usual residence 2103 W Saratoga St.

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew — DATE OF BURIAL, Sept 27 1921

20-UNDERTAKER J. Ahrens & Co — ADDRESS 1611 Mad Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 57246

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57246

CERTIFICATE OF DEATH.

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8.))

1 PLACE OF DEATH
CITY OF BALTIMORE (No.) 2009 Girard Ave ST. 13 WARD)

2 FULL NAME John A. Collins (Ages 60 yrs., 4 mos. — ds.)

(Residence in Baltimore) No. 2009 Girard Ave.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH: May (Month) 25 (Day), 1861 (Year)

7-AGE: 60 yrs. 4 mos. — ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Moulder 047
(b) General nature of industry, business, or establishment in which employed (or employer): Poole Mfg Co

9-BIRTHPLACE (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Henry Collins

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Adeline Switzer

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Mr. L. L. Chambers (Informant)
4123 Roland Ave (Address)

15- Filed Sept 26, 1921 Robert F. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Sept. (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows: Jobular disease of heart (Duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. Koerner M. D. (Coroner.)
Sept 26 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 27, 1921

20-UNDERTAKER: Horace H. Burgee — ADDRESS: 3631 Falls Rd.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57247

D 57247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2414 Druid Hill Av ST.; 13 WARD)

2-FULL NAME Robert Lane Moulton

(a) RESIDENCE. NO. 2414 Druid Hill Av ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 13 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wh	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 13/21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robert Moulton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Evelyn Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Robt Moulton. 2414 Druid Hill Av

15 Filed . 19 Registrar

Robert F. Harrison, Burial Permit Clerk

SEP 26 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26th 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1921, to P.M. Sept 26, 1921, that I last saw him alive on Sept 26, 1921, and that death occurred, on the date stated above, at 10 05 a.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

1 Day

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Teething, Cyanosis 3 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? apparent

(Signed) E. A. Schmidt, M. D.

1921 (Address) 160 N North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Sept 28 1921

20 FUNERAL DIRECTOR	ADDRESS
H. Lutz Wood Bro	Ware

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 57248

CERTIFICATE OF DEATH.

64 D 57248

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 Clifton Ave ST.) 15 (WARD)

2-FULL NAME Catherine Matilda Rarling

(a) RESIDENCE NO. 2008 Clifton Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Leonard Rarling

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Jersey

PARENTS

10 NAME OF FATHER: Charles Leeke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Ruth Reed

(Address) 2008 Clifton Ave

15 Filed . 19 Robert P. Harrison, Registrar

SEP 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 19 21

17 I HEREBY CERTIFY, That I attended deceased from Last 12 wks, 19 , to Sept 25, 1921, that I last saw her alive on Sept 25, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Grippe

2 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M.D.

, 19 (Address) 1107 Hollins

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Sept 27 1921

20 UNDERTAKER: Wm J Tickner & Son — ADDRESS: N & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57249

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57249

CERTIFICATE OF DEATH.

Doughly

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 Myrtle Ave ST.; 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Doughly

(a) RESIDENCE. No. 225 Myrtle Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Co	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter - Oto

(b) General nature of industry, business, or establishment in which employed (or employer) Oto

(c) Name of employer my brother

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Charles Doughly

11 BIRTHPLACE OF FATHER (city or town) U.S.
(State or country)

12 MAIDEN NAME OF MOTHER Jones

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Doughly
(Address) 225 Myrtle Ave

15 Filed SEP 27 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1921, to Sept 24, 1921, that I last saw h alive on Sept 24, 1921, and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ~ yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Sept 27 1921
20 UNDERTAKER	ADDRESS
Garrett Goodwin	142 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Blks.

150727 D 57250

HEALTH DEPARTMENT—CITY OF BALTIMORE

14 D 57250

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Welke

(a) RESIDENCE NO. 808 S. Glover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced (6) HUSBAND of (6) WIFE of Frank Welke Magdelena Welke 808 S. Glover St.

6 DATE OF BIRTH (month, day, and year) March 22 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Welke

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Magdelena Bialozynski

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed SEP 27 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1921, to Sept 26, 1921, that I last saw her alive on Sept 26, 1921, and that death occurred, on the date stated above, at 7 00 a. m.

The CAUSE OF DEATH* was as follows:

Dysentery - Flexner

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Stool Culture (Flexner).

(Signed) Horace G. Stewart, M. D.

9/26, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem DATE OF BURIAL Sept 27 1921

20 UNDERTAKER Stephen J. Pralkowski ADDRESS 1000 Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 57251

HEALTH DEPARTMENT—CITY OF BALTIMORE

175-001

D 57251

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Church Home St. W WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew E. Wyatt.
(Residence in Baltimore: No. 1917 Gough St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sgl.

6-DATE OF BIRTH, Feb 24th, 1910
(Month) (Day) (Year)

7-AGE, 11 yrs. 7 mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... attendant at
(b) General nature of industry, business, or establishment in which employed (or employer)..... School

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm T. Wyatt.

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Annie M. Barrett.

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm T. Wyatt
(Address) 1917 Gough St

15-
Filed SEP 27 1921, 191 M. A. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 24, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pneumonia lobar & Acute
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) [illegible] M. D.
(Coroner.)
9-27, 1921 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Parkswood Cemetery
DATE OF BURIAL, Sept 27, 1921

20-UNDERTAKER Lilly & Zeiler
ADDRESS 403 S. Mo[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57252

CERTIFICATE OF DEATH.

120 ✓ D 57252

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 North Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Matthews

(Residence in Baltimore: No. 109 North Ave Mt Washington St.: 4 yrs. 6 mos. ds.)

4 yrs 6 mos

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, March (Month) 27 (Day), 1847 (Year)

7-AGE, 74 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John C Schwarzer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eli Matthews

(Address) Mt Washington Md

15- Filed Sept 27 1921, 191.... W.F.A. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 25 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920, to Sept 25 1921, that I saw her alive on Sept 25 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Senile degeneration

Chronic Bright's Arteria Sclerosis

Contrib. Pneumonia

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Beetem M. D.

9-26, 1921. (Address) Mt Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, Sept 27, 1921

20-UNDERTAKER E. J. Marshall ADDRESS 3539 Fallsway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must be particular in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57253

D 57253

CERTIFICATE OF DEATH.

REGISTERED NO. 15 / 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1350 Stockton ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Spriggs

(a) RESIDENCE NO. 1350 Stockton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Spriggs

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) Daymt

(c) Name of employer

9 BIRTHPLACE (city or town) Easton

(State or country) Md

PARENTS

10 NAME OF FATHER John Young

11 BIRTHPLACE OF FATHER (city or town) Easton

(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Jones

13 BIRTHPLACE OF MOTHER (city or town) Easton

(State or country) Md

14 Informant Mary Weeks

(Address) 1350 Stockton

15 Filed SEP 2 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1921, to Sept 25, 1921,

that I last saw h-e alive on Sept 24, 1921,

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Wickham Fiery M. D.

, 19 (Address) 1928 Pt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters cemetery

DATE OF BURIAL Sept 28 1921

20 UNDERTAKER Joseph A Farrell

ADDRESS 2319 Division St

Spec.—7-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57254

D 57254

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3751 Morley ST. 70 WARD)

2-FULL NAME Barbara E. Gerh

(a) RESIDENCE. No. 3751 Morley ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August F. Gerh

6 DATE OF BIRTH (month, day, and year) May 8=1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Hiob

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) A. F. Gerh 3751 Morley St

15 Filed SEP 27 1921 19 I. E. Wehr Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1919, to Sept 26, 1921, that I last saw h[illegible] alive on Sept 26, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency (duration) yrs. mos. 1 wk.

CONTRIBUTORY (Secondary) Myocarditis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones, M. D.

9-26-21, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Sept 28th 1921

20 UNDERTAKER: H B Hippert — ADDRESS: 2236 Fredk ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be of certificates. TION is very important. See instructions on back of

Form 6-9-19—H. P. Co.—1000 Blks.

57255

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 57255

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1070 Raborg ST.: 18 WARD)

2-FULL NAME Clarence E Smoot

(a) RESIDENCE. NO. 1070 Raborg ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer Tobacco

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER George Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Joanes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lucian B Smoot
(Address) 508 McMechen

15 [illegible] SEP 27 1921 19 M. C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1921, to Sept 20, 1921, that I last saw h alive on Sept 22, 1921, and that death occurred, on the date stated above, at 4 to 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Adenitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) F. Norwood, M. D.

9/26/1921 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 28 1921

20 UNDERTAKER Bromwell Tilelander Schroder ADDRESS 140

N. B.—WRITE PLAINLY, with pen and ink. PHYSICIANS should state AGE should be stated EXACTLY. mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. THON is very important. See instructions on back of certificates.

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 11th DAY December

OF 1964 THE MICROPHOTOGRAPHS APPEARING

HEREIN STARTING WITH #D 54302 - June 6, 1921 AND

ENDING WITH #D 57255 - Sept. 27, 1921 ARE AC-

CURATE AND COMPLETE REPRODUCTIONS OF THE

RECORDS OF THE DEPARTMENT OF Health

BUREAU OF Vital Statistics AS DELIVERED

IN THE REGULAR COURSE OF BUSINESS FOR

PHOTOGRAPHING, AND THAT:

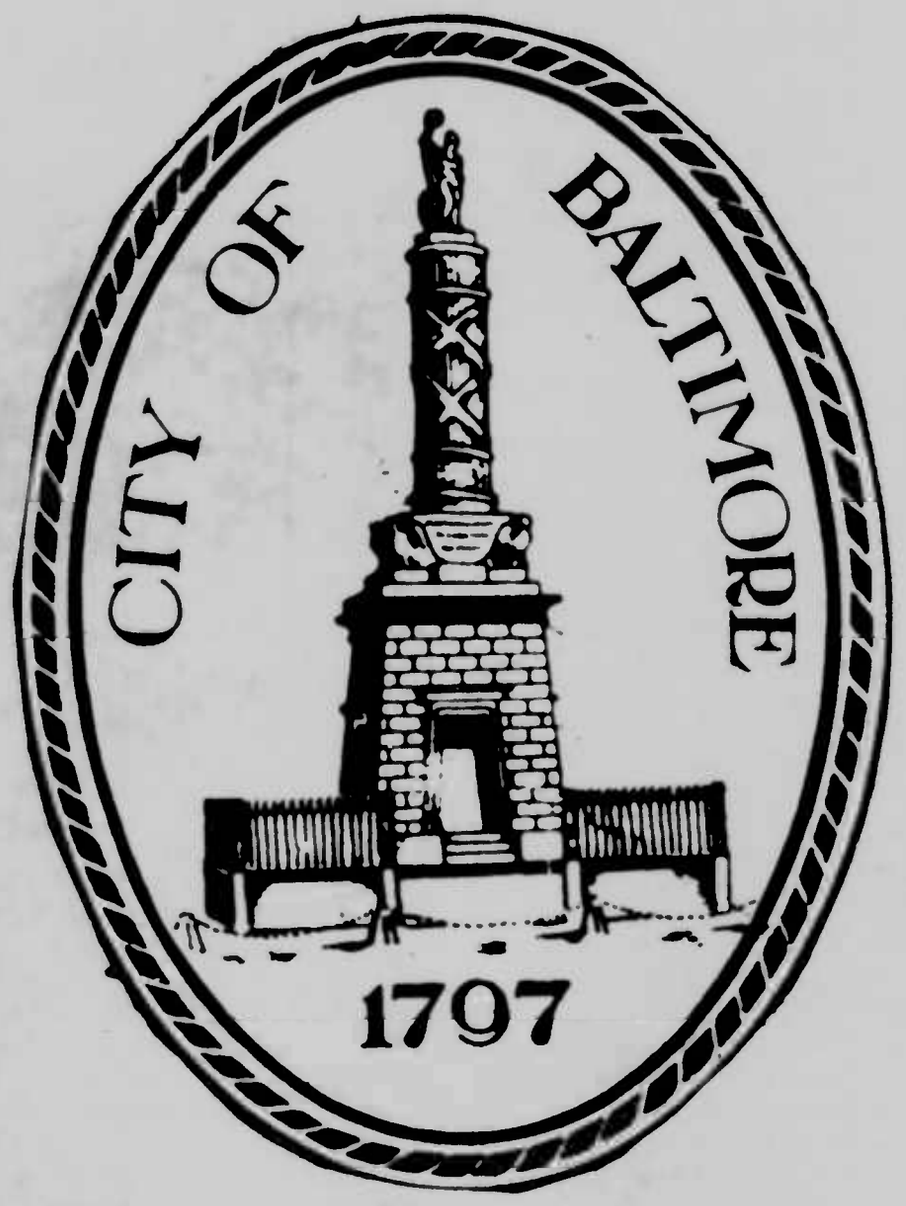
TO THE BEST OF MY KNOWLEDGE THE MICROFILM

MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU

OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC

COPY.

CAMERA OPERATOR: D McFaul



END OF REEL